GUY'S HOSPITAL GAZETTE
February 1991

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GUY'S HOSPITAL MEDICAL SCHOOL

- Mr A K Yates — a tribute
- The Role of Media Medicine — by Dr Vernon Coleman
- 407 Art Club — the Christmas exhibition
- An Englishman Abroad — an interview with Mr Ken Gilchrist

A World of Experience

Founded 1892

The Medical Protection Society

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Guy's Gazette

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Volume 105 Number 2409 Feb 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

Well here it is at last. The Gazette has returned to the A5 format and now sports a colour cover depicting the Guy's Hospital crest, which will be a constant feature throughout the year. We hope that the new style will provoke a favourable response and look forward to receiving readers' views on the subject.

At the end of last year a deal was finally struck between the Government and junior doctors' leaders, which aims at reducing hours to a maximum of 83 a week, and then to a mere 72 per week.

I know that since the dawn of time junior doctors have worked ridiculous hours, but it is still surprising that a 72 hour working week can be regarded as a victory. Nevertheless, many of the changes are welcome.

The new system sees a move towards a pool of juniors working for two or three consultants. This will allow doctors to draw on a wider source of clinical experience and will reduce the impact of personality clashes between consultants and staff.

However, the deal to reduce hours may strain relationships between consultants and junior staff. Although the BMA Central Consultants and Specialists Committee debated and subsequently agreed the changes, the Hospital Consultants and Specialists Association (HCSA) were not party to the discussion. The HCSA fears that seniors will become glorified senior registrars under the plan and will be obliged to fill the gaps left by the reduction in juniors' hours. Apparently, an average consultant already works in the NHS for 10 hours longer than stipulated in his contract.

The answer to these problems lies, of course, in the creation of more hospital posts. The Government has agreed to fund an extra 200 consultant posts and 50 staff grade doctors but this, according to the HCSA, is inadequate. If junior and senior medical staff were to join forces—rather than snipe at each other—they could lobby the Government more effectively, and perhaps resolve this long-standing problem.

GP Training

Dear Sir,

'Significant room for improvement in the way family doctors are trained', you quote in November's *Gazette* from a RCGP's report.

The same thing used to be said when I first went into general practice in 1952, before the RCGP was born; but I've never agreed with it. I think the training we received at Guy's gave us all we needed to know: what we had to learn was how to use it.

Apparently 70% of doctors complained that they were not told how to talk to patients. And a damned good thing too, I should say. At Guy's we were taught to listen to patients, not to talk to them; and I hope this is still the case, for otherwise there'll be no doctors in the future, only guessers (with greater or less luck) and computer operators.

If talking's to be taught at all, don't leave it to medical experts. Two days ago I got a journal written by consultant neurologists on the subject of migraine, and purporting to tell us lesser mortals how to treat that common disease. At a guess, the average neurologist would see the average migraineux for about ten minutes in his lifetime; but the average GP would see him through his tribulations month in and month out.

So what did His Eminence advise? 'Migraine patients should avoid psychological and environmental stresses.' That was his ten minutes' talk to a patient.

Once upon a time, the European president of 'Heinz—57 Varieties' was one of my patients, and he told me he'd consulted an eminent physician—I forget what about—who said to him, 'Of course you've got no worries!'

'I walked out of the room,' he said, 'and never went back. Anyone who could make such a crass remark could have nothing of any value to say to me.'

If there were some miraculous means by which a patient could be shielded from stress, the last patient it could benefit would be the migraineux. Why? Because he is a stress-addict.

It is usually easy to diagnose the condition; but how do you to convince someone who thinks he has a cerebral tumour, without sending him away for expensive electronic investigations? What I do is ask which day of the week he most commonly gets his headaches. He looks at me as if I were mad; but after a little thought he says, 'Well, funnily enough, it's usually Saturday.' And a new respect for my clinical acumen begins to dawn.

God said, 'Six days thou shalt do thy work, and on the seventh day thou shalt rest.' He might have added to all migraine-sufferers, 'If thou thinkest to rest on the sixth day also, thy head will become like unto an autoclave, and thy stomach as The Blackwall Tunnel in rush hour.'

Do let us continue to listen to our patients, and leave the talking to politicians. If I might quote once more from the Holy Bible, 'Even a fool is counted wise when he holdeth his peace.'

Yours faithfully,

CHARLES STEER
25 Gloucester Rd
Kingston on Thames

Ophthalmology Teaching

Dear Sir,

I notice in 'Passim' (November) that opthalmology has been forgotten as a teaching subject. It always is. It is strange that one of our major pieces of equipment—necessary now to see all the computer demands—is so neglected.

In 1949 the Wills Library introduced a new indicator board for its shelves. Every branch of medicine was supposedly sign-posted, but only as an afterthought was 'Eyes' written in half the size of the print of the other subjects.

Guy's is not the only place to overlook ophthalmology. A hospital where I worked put up notices for outpatients. At the bottom, again in miserable print, was 'Eyes'—it was an eye test in itself. Words fail to describe the sadness and ignorance of this neglect.

Yours faithfully

P A GARDINER
Rogue's Cottage
Wickham Market
Woodbridge
Suffolk

Scrap UMDS

Dear Sir,

May I suggest a change in title for UMDS. Having conducted a straw poll of students, and having borne the brunt of many students' displeasure with the name, I feel that the majority of students on both campuses would welcome a change.

The name UMDS has, as yet, no significance for the public and therefore will hinder fund raising activities, such as Charities Week, nor has UMDS any historical traditions to draw upon in academic and sporting fields.

I propose a change in the present emphasis, with UMDS being bracketed, and Guy's and St Thomas' Hospitals becoming the main title. The use of the hospital names in this way would have considerable benefits.

Yours faithfully,

R RUSSELL
Boland House

Alan Yates

Dear Sir,

Alan once told me how much he had enjoyed his stay in South Devon during the war. As a small boy he had been evacuated to a little hamlet just outside Newton Abbot. It is now South Devon's turn to say how indebted we have been to Alan who over the years has advised and treated so many of our local people. All of his Devon patients regarded him with gratitude and great affection, feelings which he earned not only for himself but for Guy's—the hospital that he served so well.

Yours faithfully,

TOBY THORNE
Brook House
Ringmore Rd
Shaldon
South Devon

Where To Be Born

Dear Sir,

There are three *obiter dicta* I shall always remember when this question is discussed, namely:

'Pregnancy is normal in retrospect.' Professor W C W Nixon, of UCH.

'Domiciliary Midwifery should be as dead as the Dodo.' Sir Arthur Claye.

'The best place for the mother is in Hospital; the best place for the baby is at Home.' A very experienced Midwife.

With all of these I heartily agree although I would modify the third one.

It must be frankly admitted that nobody can predict with absolute certainty that any pregnancy will be normal, by which I mean that at the end of nine months there will be a happy, undamaged Mother and a healthy undamaged baby after a normal spontaneous delivery. We try to anticipate disaster by adequate antenatal supervision and advice but can anyone predict foetal distress or a post partum haemorrhage? Admittedly ninety percent of pregnancies are normal—it is, after all, a normal physiological process, but there are still times when Nature needs a little help, and until we can anticipate with certainty that a woman will have a normal delivery then dictum two is inevitably true.

I would amend the third and substitute: 'The best place for the Mother is in a suitable delivery room where expert assistance is available night and day.' That means an Obstetric Unit should be adjacent. When we designed the new Obstetric Unit at Pembury six delivery rooms were suggested for normal deliveries. These were made as simple, comfortable and homely as possible, and the husband or friend could stay with her during that tedious first stage. I was always happy to allow husbands to be with their wives during the first stage. but the second stage is not a particularly glamorous occasion for a woman, positioned with her legs pulled up, straining and getting purple in the face with exertion and not looking her elegant best. I also hoped that the GP, and District Midwife would use these rooms and deliver their own patients and, if all went well, then the woman and baby could return home as soon as convenient and resume care under the same team. The main Obstetric Unit would not be called in at all, but, if there had been an emergency, there it was, instantly available.

I also started an Emergency Flying Squad at Pembury and have some experience of answering calls for help! I wonder if the author, whose article I read with great interest, has ever been on such a call? If not I recommend coming to such a call on a foggy November night, trying to find one's way to some remote house in rural Kent or, in September, a hopper's hut in pouring rain across fifty yards of thick mud, the latter without light, water or even a chair to deal with a girl with a PPH after delivering herself lying in the corner on a bundle of sacks. With the exception of a sudden ante partum haemorrhage the Flying Squad indicates a failure of supervision somewhere along the line and, like Domiciliary Midwifery should be an anachronism.

I was always indebted to that Midwife I quoted earlier—the safest place for the delivery of an expected normal delivery is in the GP Unit of The Hospital Obstetric Department, while the safest place

for the baby afterwards is at Home. It would be an interesting statistical study to enquire how many doctor's wives are delivered at home!

But, as the saying goes: 'There are lies, damned lies and statistics'.

Yours faithfully,

E D Y GRASBY
Fothersby West
Hawkhurst
Kent TN18 5DB

Feeling the Cold

Dear Sir,

I wonder how many regular readers of the *Gazette* find it necessary on the touchline or tow path, or elsewhere in the chill of winter, to fortify themselves with the contents of a Hip Flask. Yet, on p. 146 of the September *Gazette* these archaic items are advertised, bearing the Guy's crest, for just this purpose. The advice is not even physiologically sound.

What would the world think, if they were to study the *Guy's Gazette*, a time honoured hospital journal, plugging the virtues of a shot of neat spirits (for that is what is implied) to keep its regular readers warm? I ask you?!

Yours faithfully,

DONALD DAWSON
10 Urch Rd
Roleystone
W Australia

Honorary Fellows

Dear Sir,

Many colleges and universities from time to time elect Honorary Fellows to honor those of their alumni, or others who have been associated with their institution, who have achieved national or international stature in their fields. I write now to suggest that Guy's Hospital Medical School might consider a similar award to honor those of its alumni or staff who have reached eminence in their respective disciplines.

As examples, that come immediately to mind, I have in mind such illustrious Guy's men as Lord Butterfield, Sir Roy Calne FRS, Professor Paul Polani FRS, and Sir Terence English PRCS, all of whom have achieved distinction. The honorees could be honored at an annual function such as a degree ceremony, or possibly at the biennial dinner. The cost to the Medical School and Hospital would be negligible, and yet Guy's would benefit by drawing public attention to its outstanding alumni and staff.

Yours faithfully,

D K C COOPER
Oklahoma Transplantation Institute
Baptist Medical Center
Oklahoma City, Oklahoma, USA

Deal to Cut Junior Doctors Hours

About £14 million is to be spent by the Department of Health this year to create an extra 200 consultant posts and 50 additional medical jobs as part of an agreement to reduce the hours of junior doctors.

Virginia Bottomley, the Health Minister, announced a programme, to be reviewed each year, aimed at reducing hours to a maximum of 83 a week, and then to 72 per week.

Junior doctors would work shift systems in busy specialities such as accident and emergency, paediatrics and obstetrics. Partial shifts will be encouraged in other areas, concentrating manpower during the day but allowing time off at night and weekends.

The system of juniors working under a particular consultant in 'firms' will move towards a pool of juniors for two or three consultants, allowing more flexible cover.

More use would be made of the skills of nurses and midwives to take on some jobs done by juniors. The medical royal colleges, which supervise training, are to review the mix of doctors needed at night.

Regional taskforces are to be set up to supervise the work of health districts in implementing the changes, and the ministerial committee chaired by Mrs Bottomley into juniors' hours will continue to review progress.

Junior doctors' leaders said their agreement was conditional on the proposals being implemented quickly. Detailed guidance and local plans are due to be in place by April.

A new pay contract will also be drawn up for juniors with the aim of keeping the salaries on a par with current earnings.

One Small Step Appeal

Viewers and staff of BBC–1's The Clothes Show have raised £10,000 for the charity One Small Step which will help to provide a Movement Analysis Laboratory at Guy's Hospital in London. This will benefit surgeons treating young people with cerebral palsy.

The money was raised from the sale of admission tickets to the finals of The Clothes Show's Models 90 competition at Brighton, and from sales of T-shirts and other efforts by BBC Pebble Mill staff working on The Clothes Show.

The cheque was presented to a young patient of Guy's, Emmett de Monterey, who travelled from London to The Clothes Show Live at the National Exhibition Centre to receive the cheque. It was handed over by presenters Jeff Banks and Selina Scott, and Models 90 winners Lisa Roudette (from Essex) and David Green (from South Shields).

Emmett was invited by Selina and Jeff to join them at Models 90 (and later at the NEC) when he appeared on a QED programme in March about cerebral palsy and said The Clothes Show was his favourite programme. Since the presentation he has returned to the USA for further operations.

Preparing Patients

Preparing patients psychologically for surgery reduces post-operative pain and the length of stay in hospital. A survey of studies done over the past 25 years has produced 'quite persuasive' evidence that patients who are prepared for surgery fare better, feel less pain, need fewer painkillers and are discharged from hospital sooner. The survey, by Dr Marie Johson, of St Andrew's University, identifies there kinds of preparation that have proved their value. The first is information about what the patients are going to feel. A patient warned that he may have a stabbing pain is less likely to worry about it than one who thinks it means that his surgery has gone wrong.

The second is guiding people to avoid pointless worries by encouraging them to think of other things, and the third is training in relaxation. These methods, Dr Johnson says, can have clear and quantifiable benefits to patients.

Student Counselling

Paul Ravli has been appointed as counsellor for medical and dental students. He is based at Riddell House, room 107, St Thomas' campus (ext 3141). He will be working on Wednesday afternoons, Thursdays and Fridays and hopes to allow an hour between 10 and 11 a.m. on Fridays when he will be free for personal callers or telephone calls. The counselling post at Guy's is to being set up.

Student Loans

For 1991 Student Loans will be dealt within the School Office. All home fee paying students on the MB BS, BDS and BSc courses will normally be eligible for a loan which will be issued direct to students by the Student Loan Company.

New Professors

There have been three new appointments to professorships. Dr John Weinman will be the new professor of psychology applied to medicine. Dr T H Grenby becomes professor of nutrition in relation to dentistry and Dr P G J Burney is now the professor of public health medicine.

Sir Terence English

Terence English the President of the Royal College of Surgeons, and who trained at Guy's Hospital, was knighted in the New Year's Honours List.

Student Support

The White Paper—Top Up Loans for Students—announced the Government's intention to establish Access Funds as part of new arrangements for student support.

The purpose of the Fund is 'to enable high and further education institutions to provide financial help to students where access to higher education might be inhibited by financial considerations or where students for what ever reasons, including physical or other disabilities, face financial difficulties'.

All full-time home students on the BDS, MB BS, MB BChir, MSc and PhD course are eligible to apply. The School has been allocated some £50,000 in respect of undergraduate students and £4,000 in respect of postgraduate students.

The School has established a panel to consider applications for support for these funds and the panel will consider applications on a regular basis. Application forms may be obtained from the Registry at St Thomas's or the School Office at Guy's and should be returned to the Academic Registrar.

In considering applications the panel will use the following criteria:

1. The student must be able to show financial hardship. Students will, therefore, be required to set out their regular income and expenditure.
2. Undergraduate students must have applied for a Student Loan.
3. Students will not normally be eligible for awards if they are living in School or University Halls of Residence.
4. Students living in the parental home will only be considered if they incur exceptionally large travelling expenses.
5. Priority will be given to students whose fees are not met by a local education authority award.
6. Students in receipt of a minimum (fees only) award from a local education authority will only be considered in exceptional circumstances.

Guy's Bournemouth and Wessex Society

The thirty-fifth annual dinner of the Society was held on 2 November at the Durlston Court Hotel. The Guest of Honour was Professor R A C Hughes, who gave an account of the building progress at Guy's and a variety of anecdotes about present doctors at the hospital.

At the AGM Mr A K Parsonage was elected President, Mr E H Archard was elected Honorary Secretary and Miss A M Sedgwick was elected Honorary Treasurer.

Professor Adams

Professor A P Adams has been unanimously elected to the Chairmanship of the Anaesthetic Research Society.

Now Wash Your Hands

Doctors and nurses in hospital do not wash their hands often enough or thoroughly enough, and improvements would saves lives and money. These were the conclusions of a group from Liverpool University which carried out a survey in two teaching hospitals in Liverpool and London. Although doctors and nurses know that one patient in ten admitted to NHS hospitals acquires an infection unrelated to the reason for admission, and that the failure of medical staff to wash their hands is the most common cause, the researchers found it hard to improve hygiene standards.

The cost in pain and additional expenditure of cross infections is considerable. A survey in 1983–84 in one teaching hospital showed that the additional length of time spent by infected patients in hospital cost £1.25 million, not counting the additional costs of treatment.

Guy's Hospital East Anglian Society

The Society will meet at the Moat House Hotel, Copdock, Ipswich, on Saturday 6 April at 7 p.m. for 7.45 p.m. The President for the evening will be Mr Hujohn Ripman, FRCS, FRCOG, and the guests of honour will be Professor and Mrs T J H Clark.

Details, including application forms, will be sent to all Guy's East Anglians who have responded in previous years. The Secretary would welcome any new names to this important event, and enquiries should be sent to the address below:

Mr B A Ross
Norfolk and Norwich Hospital,
Brunswick Rd,
Norwich
Norfolk
NR1 3SR

Sarah Stolz Lecture

The Sarah Stolz Lecture will be delivered on Thursday 28 February 1991 at 5.00 pm in the Lecture Theatre, Floor 30, Guy's Tower by Professor William Parry-Jones, MA MD FRCPsych, Professor of Child and Adolescent Psychiatry, University of Glasgow, on The Impact of the Air Disaster on the Children of Lockerbie.

All Welcome.

Friends of Guy's Hospital

The Friends of Guy's Christmas Stall was held on 29th November in New Guys House and raised £1288.62 for the benefit of patients and Staff of the hospital.

We are most grateful to everyone concerned, those who manned the stall, those who bought and those who gave gifts to sell.

Please accept our thanks.

Clinical PET Centre

On 20th December, Professor Ian Cameron signed a contract with Siemens Plc to purchase the equipment to establish the first Clinical PET Centre in Britain. This venture is a collaboration between Guy's, St Thomas' and UMDS.

Positron emission tomography (PET) is a functional imaging technique which makes it possible to measure regional chemistry in the living body. It has allowed many disease processes as well as normal function to be redefined and understood in terms of altered chemicals reactions rather than based on morphological criteria.

PET has developed as a biological research tool, providing a mass of new information about brain, neurological and cardiac functions, as well as better understanding of many diseases.

PET is being applied as an important clinical diagnostic imaging technique in North America, Europe and Japan with over 50 centres worldwide but not one single clinical diagnostic centre exists in the UK.

Our project will consist of a radioisotope production and chemistry labelling facility based at St Thomas' which will supply radiochemicals for diagnostic use with patients at both hospitals, each of which will operate its own imaging suite. It is anticipated that the first patient will be scanned in January 1992.

The project will cost approximately £5 million and a fundraising appeal will be launched in Spring 1991. The new centre will provide the first diagnostic PET service in the UK, will offer important opportunities for clinical research evaluation and most importantly will provide a significant clinical benefit for British patients from London and the rest of the country.

Change of Style

William Waldegrave, the health secretary, called for bridge building between doctors and politicians, and openly criticised the 'supermarket' language used by his predecessors.

Mr Waldegrave's remarks in the Trafford Memorial Lecture to the Royal College of Surgeons were in marked contrast to the confrontational approach of his predecessor, Kenneth Clarke.

He said that his intention was 'to build bridges between politics and the medical profession', and he emphasised that the commercial approach to the health service should not be overdone. Mr Waldegrave went on to say: 'The NHS is not a business; it is a public service and a great one. I think we have overdone the language of commerce in relation to the NHS. We have been carried away by our enthusiasm for what we have borrowed and we have alarmed quite a lot of people who think we do not know the difference between a hospital and a supermarket.

'Our "customers" do not come because the price of beans is less, or because of the pretty girl in the advertisement; they come because they are ill . . . they want help and expect care.'

Mr Waldegrave stressed that there was no difference in policy between himself and his predecessor.

Alan K Yates

A tribute

It is with a sense of great tragedy that we report the death of Alan Yates, Director of Cardiac Surgery, Guy's Hospital at the age of 57 years. He qualified in Sheffield and first came to Guy's in 1964 as Senior Surgical Registrar to the Thoracic Unit when Lord Brock was the Senior Cardiac Surgeon. His *curriculum vitae* then showed the following distinctions.

University Medal for 2nd MB, ChB—Awarded Honours
University Medal for Final MB, ChB—Awarded Honours
John Hall Gold Medal in Pathology
Holroyd Prize for Anaesthetics
The West Riding Panel Practitioners Prize in Clinical Medicine
The Dr Mark Gregory Baker Prize
Arthur Hall Prize
Albany Scholarship

Rarely can anyone have picked up so many honours on graduation day. The following day he married Enid. Not mentioned in the CV is the fact that he was a very talented swimmer and had already represented Essex and Yorkshire. More than that he was a member of the British Olympic Swimming Team in 1954, often doing his training at mid-night while still a student. He of course held prized pre-registration posts on the Professorial Surgical and Professorial Medical Units at Sheffield.

He was one of the last doctors to do National Service and it is hard to imagine him square bashing. In fact he avoided this because the army wisely recognised both his excellence at swimming and his organisational abilities and made him captain of the British Army Swimming Team. After working at the Cambridge military hospital he went to Gibraltar for a year where he was the sole Military Surgeon to a population of 20,000 service people and their families. He returned to Sheffield intending to become a rotating surgical registrar and obtaining his final Fellowship but as a stop-gap he worked on the Cardiothoracic Unit for Desmond Taylor, himself a Guy's trained cardiac surgeon. This fired his enthusiasm for cardiothoracic surgery and having completed his surgical training he applied for and was appointed to a Senior Surgical Registrar post at Guy's working for Donald Ross and Lord Brock. He was at Guy's from 1964–1968 where three of his very obvious features made him a natural successor to Brock himself. They were his astounding energy, his total devotion to looking after his

patients with the highest possible standards and of course his great intelligence. However the post of consultant cardiac surgeon at his own teaching hospital became vacant and in February 1968 he was appointed consultant cardiothoracic surgeon to the Sheffield Regional Hospital Board. Brock would have preferred him to have applied for, and been appointed to, the Brompton Hospital.

It is interesting that the problems that beset him in Sheffield were little different to those still affecting the Health Service now. There was a shortage of money and a shortage of facilities. Mr Yates felt that he was being held back and even in those days invoked the assistance of the Press to try and generate enthusiasm for creating a British made valve which ought to be cheaper than the American competitors. This ready recognition of genuine injustice and a willingness to try and obtain national support through the media were to typify much of his subsequent approach to the inadequacies of the Health Service. When Guy's were looking for a successor to Lord Brock there seemed to be only one obvious person and Alan Yates was overwhelmed by Guy's doctors asking him to return. This combined with the disillusionment with the facilities at Sheffield led to his natural accession to the post of Cardiothoracic Surgeon as Brock's direct successor.

Alan Yates tackled the role of consultant cardiothoracic surgeon at Guy's with a vigour and enthusiasm that those who worked with him will never forget. (As a Registrar he had been so involved with his work that he only learnt of the birth of his son Neil several days after it occurred). Cardiac surgery these days is so routine that one forgets what it was like in the late 60's and early 70's. Operations took far longer than they now do and the intensive care period was both fraught and frenetic. Alan Yates virtually lived in the Unit and was barely separated from his patients. He was very fortunate in being supported by his wife and family during this demanding time. Apart from his cardiac surgery, Alan will always be remembered at Guy's for his directorship of the Intensive Care Unit. Until the very recent appointment of an intensivist at Guy's, intensive care was always Alan Yates' 'baby'. His approach to intensive care was astoundedly single minded, the only factor of importance being that patients should receive the best possible care available. The morning ward rounds initially on Cornelius and then on Russell Brock ward will be remembered by almost anybody who attended. Heaven help any doctor whose approach to patients had been anything less than first rate. Alan could be utterly ferocious if he felt that a patient's care had been compromised, yet on the other hand he could sit down for hours with a receptive junior doctor explaining the details and principles of the optimal management of a

critically sick patient. There is no doubt that the Intensive Care wards at Guy's would not have achieved their reputation if it had not been for his steadfast and resolutely uncompromising approach to trying to obtain the best quality of care for patients on the Unit. The nursing staff loved this approach, especially as he supported them through thick and thin in order that 'his Unit' should remain the pinnacle of care within Guy's.

The fundamental principle of his clinical practice was that **every** patient should be treated as if they were one's own nearest and dearest. He hated slipshod or what he termed sub-optimal treatment and many doctors who failed to meet his exacting standards will have been the recipients of his wrath.

With the recent developments in the Health Service he inevitably became more involved in administration and became Director of Cardiothoracic Services at Guy's. He was never happy with committee work and although he pursued his administrational activities with the same enthusiasm as he had his clinical activities he found the problems of management far more frustrating than any clinical problem that he had met. Yates and frank open honesty were synonymous and the political machinations associated with the bureaucracy of administration were often anathema to him. He strove to prepare the Cardiothoracic Unit to be in the best possible shape to enter the new era of Trust Status. At the time of his death a new Paediatric Cardiac Surgeon had been appointed to Guy's and the ward was completely updated, developments unfortunately that he was never to see completed.

Apart from his devoted clinical activity, Alan was just as enthusiastic a family man. He loved parties where his expansive personality and sense of humour could burgeon. He was a keen sailor and it was well know that he intended to take early retirement at the age of 60 years and then to push off round the world in his boat to enjoy what to everyone were the well deserved fruits of his selfless existence. That he and his wife should be denied this is a great tragedy. To many, Alan Yates was a great bear. To the nurses on 'his wards' he was a cuddly friendly bear who could be relied on for warmth and protection. To any doctor who did not display the highest clinical standards, he was a ferocious, grizzly bear and one walked in peril. He was never a dancing bear. His impact on the staff of Guy's, his patients and anyone else who knew him will never be forgotten. We express our deepest sympathies to Enid and his four sons.

JED

407 Art Club

The Christmas Exhibition

This was a popular and lively show, brightening the wet, greyness of December and providing a colourful diversion from the preoccupation with balanced budgets, ward closures and the gloomy predictions of some hospital pundits.

The exhibition was held in the customary venue of the Studio on the top floor of Hunt's House. On entering the room one's attention was caught by a large, lugubrious fish. This brilliantly coloured oil by Natasha Crowcroft was one of three paintings by the artist. A fish was the subject of another of her oils. It was a different colour and who would have thought that fishes could be so expressive? The third was a bright patchwork of North African palms and houses entitled Morocco. This was her best work, a well constructed and warmly coloured picture.

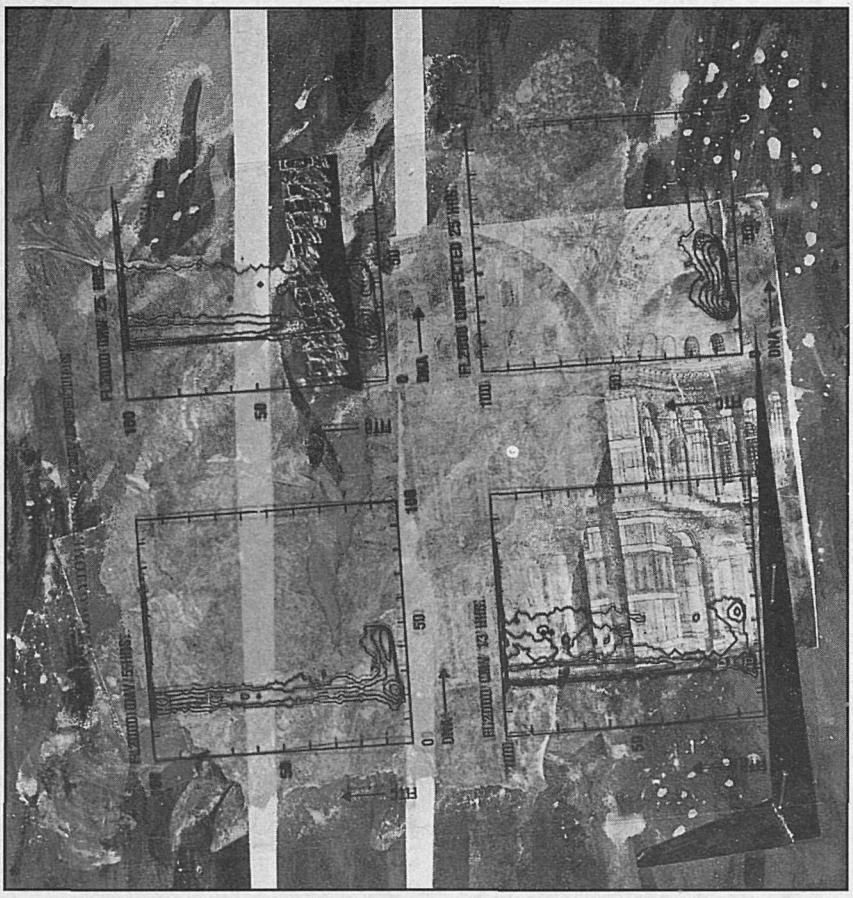
Two beautifully executed drawings by Diona Podara attracted much favourable comment. These were of a Greek fisherman and a woman with a child. The subtle pencil work revealed a high degree of craftmanship.

There were some regular exhibitors on show. Amongst these was Peter Schurr who chose to enter two oil paintings. One was a bright garden scene entitled Spring at Irstead. The other was a misty view of Greenwich from the Isle of Dogs. Both pictures conveyed a keenly felt sense of mood and atmosphere. Their excellent quality was in keeping with the many previous paintings exhibited by Peter at the 407 shows.

Despina Savva, an illustrator from the Graphics Department, showed a colour pencil sketch of a domestic scene entitled Warm and Comfortable. Her other entry was a fine zoological drawing of a rhinoceros.

Susannah Nasskau from the same department revealed her professional training with two watercolours. She included another animal subject in the immaculately drawn Charolais Bull. Her other work was a landscape of Lake Padarn. Both pictures were admired for their attention to detail.

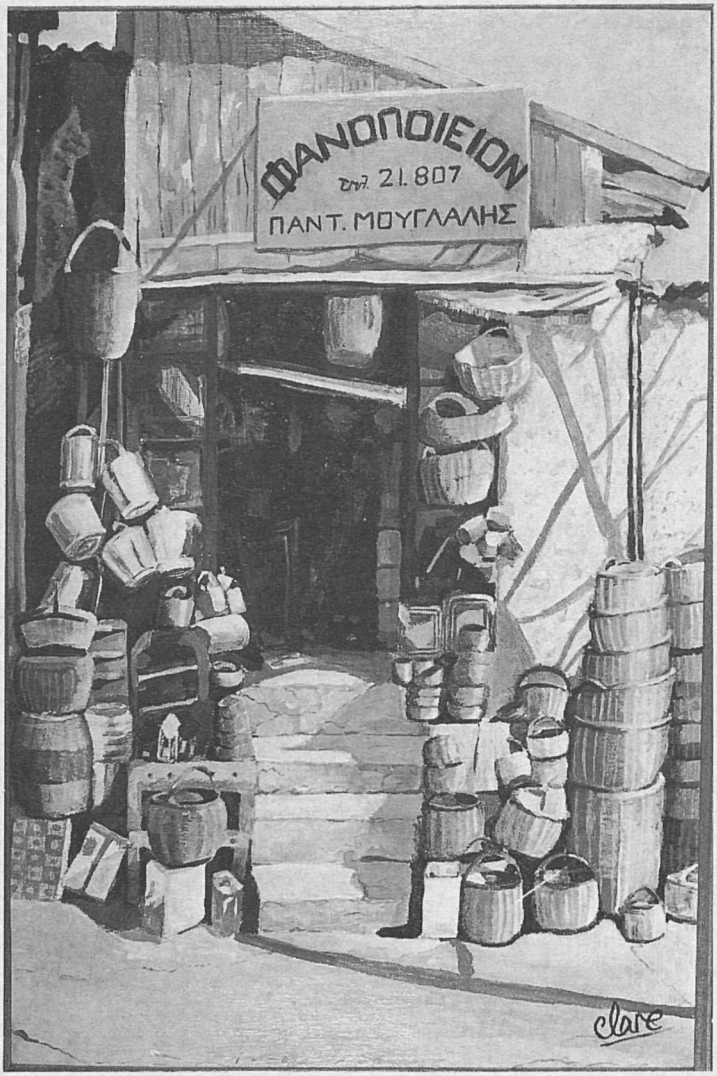
A very nice oil painting, Plum Blossom, by William Mann revealed his characteristic Impressionist-like style at its best. It was accompanied by a striking abstract composition entitled Ultramarine. This was a departure from Dr Mann's usual choice of subject. His third picture was a watercolour view of a cottage in France, a restrained and effective use of the medium. His work is increasingly admired.



Above: '2000 CMV' by M Adinolfi

Pen and use of a delicate wash were the techniques used by Maggie Bickers for her two garden scenes. These were pretty views of flower beds, a pleasant evocation of summer.

Jenny Cameron is a professional artist and the quality of her work gave every indication of this. Sleeping Girl was an oil painting of a nude figure. The pictures which attracted more attention were one small picture of



Above: 'Baskets' by Clare Walford

nasturtiums and two large watercolours of floral arrangements. These were superbly executed and being last on the catalogue they made a triumphant finale for a memorable exhibition.

The engravings by Sidney Leibowitz were revelatory. He has been a contributor to the 407 Art Club since its inception but has been reluctant in latter years to show his work. We now know that he has spent this time perfecting his skills. There were six highly appealing engravings and silk sheen prints which would grace any wall. It is hoped that Sidney will continue to produce and show his work at forthcoming exhibitions. Perhaps he might even consider offering it for sale—there would be no shortage of purchasers.

Next to Sidney Leibowitz's work were the witty and stylish collages of Matteo Adinolfi. His talent and productivity have made him a mainstay of the 407 Art Club. The titles were as imaginatively enigmatic as the pictures themselves. Matteo's flair for colour and shape were allied to his adventurous choice of materials to produce a series of nine delightful pictures.

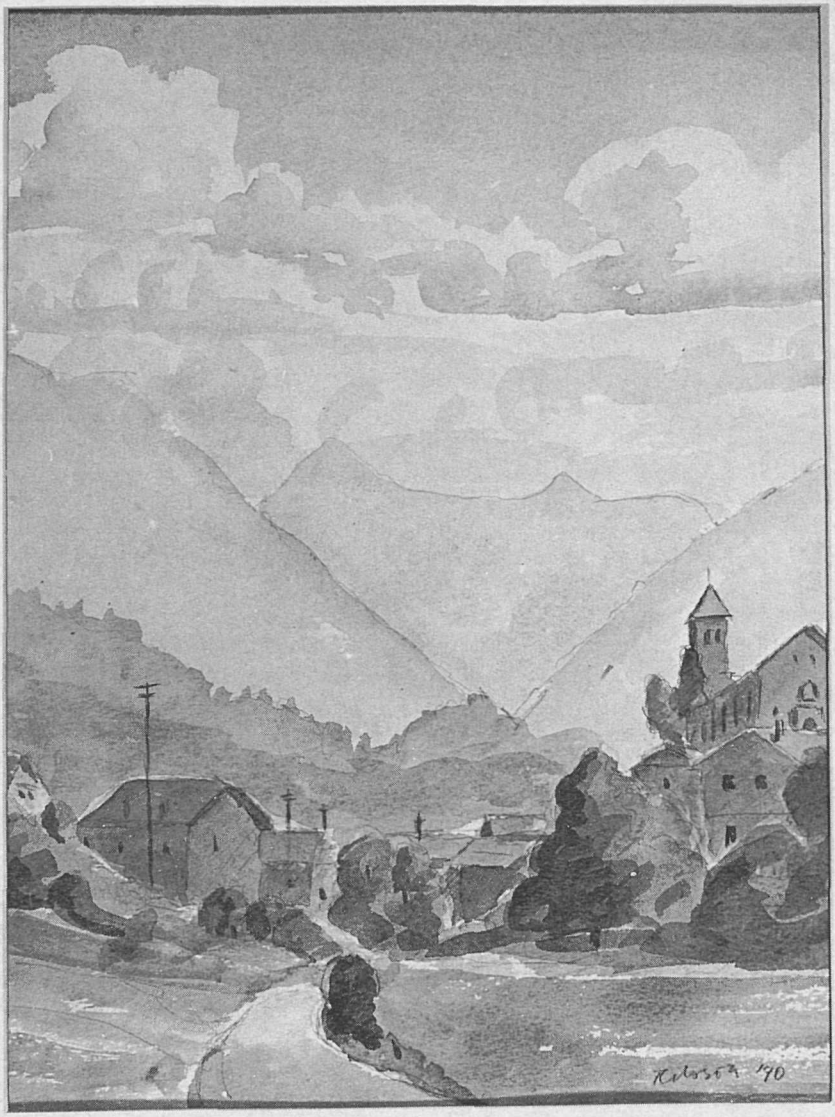
Clare Walford chose to exhibit an oil painting of baskets hanging in the doorway of a Greek shop. The use of light and shadow were technically outstanding and the overall effect was of a skilfully worked, well designed painting of considerable merit.

Terry Gibson contributed seven watercolours of recently visited locations. Most were of the Vanoise in France but Bermuda and Karachi also featured.

Jane Gibson's ceramics occupied the centre of the exhibition. There were twenty vases, bowls, boxes and other vessels. Porcelain predominated but her Raku-fired exhibits displayed an equal delicacy and flare. All of these items were for sale and demand was brisk.

The 407 Art Club is to be congratulated for its continued attempts to expand the cultural activity of the Hospital and School. This was another successful exhibition and the Club had the satisfaction of introducing several artists who had not previously displayed their work to a wide audience at the Hospital. The next exhibition is likely to take place in the summer and new contributors are welcome. Anyone wishing to participate should contact Dr Gibson.

Our Art Correspondent



Above: 'Champagny en Vanoise' by T Gibson

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The Rôle of Media Medicine

A personal view by Dr Vernon Coleman

Dr Vernon Coleman is Britain's best known media doctor. He has written 45 books, syndicates a medical column worldwide, as well as writing for The Sun newspaper and providing a hugely popular telephone doctor line.

He writes for the Gazette explaining the role of media medicine and his part in it.

I know I'm doing a good job because the old bores who work and gather in BMA House hate me. I'd be terribly worried if they didn't. If they weren't forever writing lengthy, unreadable letters of complaint I'd be very upset.

The simple truth is that the BMA exists to look after doctors salaries and working conditions. And most of the rest of the medical establishment is committed to protecting the interests of the medical profession.

My job's different.

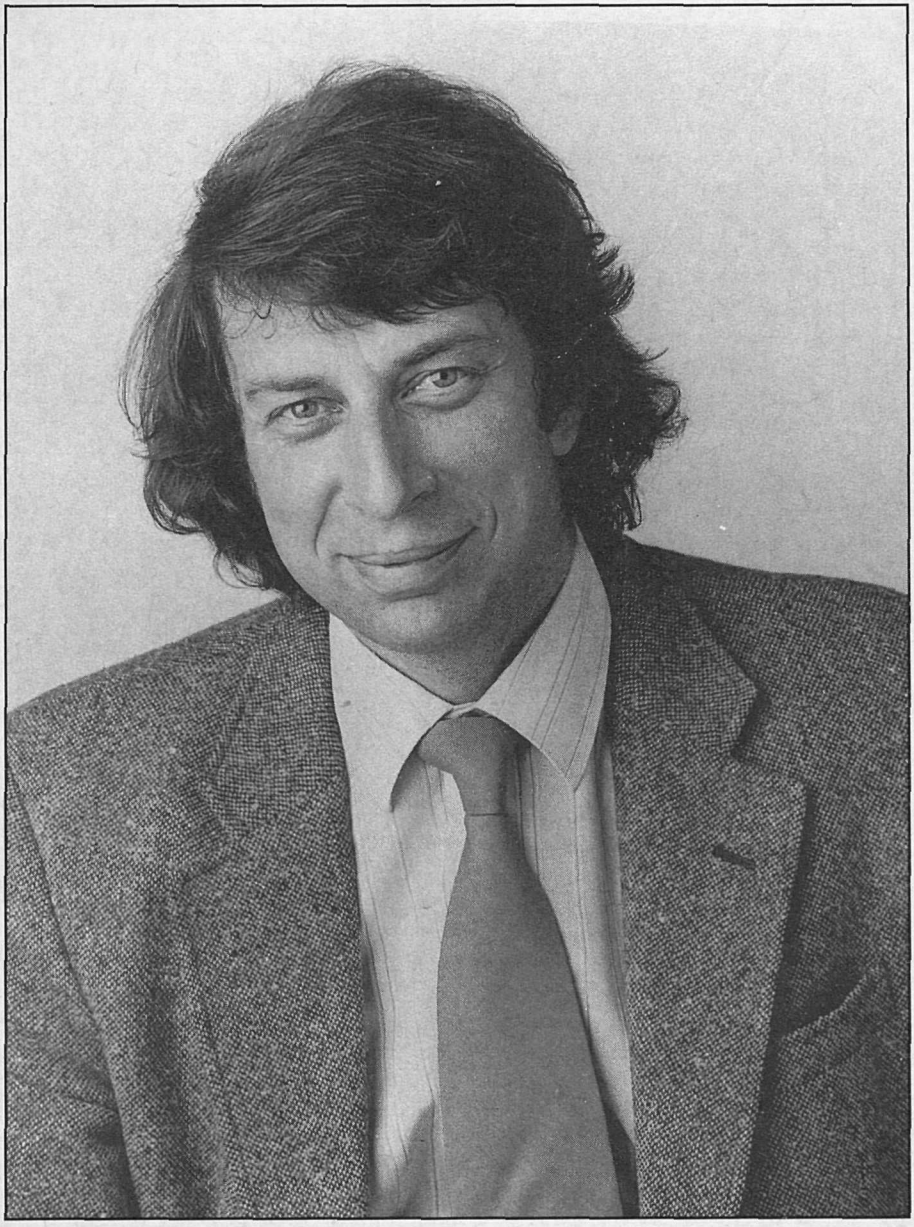
I'm paid to look after patients interests. I am, I suppose, a gamekeeper turned poacher. Its my job to use my medical knowledge—and my knowledge of how the system works—to advise patients on how they can get the best possible deal from the system. I write a lot of stuff designed to show readers how to stay healthy, how to spot symptoms that are important and how to treat themselves. But a big part of my job is exposing frauds and scandals and inadequacies that the medical establishment would rather keep quiet.

Generally speaking media medicine in Britain today is in the same sort of state that surgery was in during the seventeenth century. It is primitive and crude and much of it does more harm than good.

There are three easily definable aspects to the job.

First, and most obvious, it is the role of the media to inform. Twentieth century patients are brought up to expect far more information than most doctors have the time or the training to provide. Patients want facts. They want to know what options are open to them, what alternatives are available and when to expect signs of improvement.

Patients want to know what they can do themselves, whether they should rest or go to work and whether or not they have to give up sex.



They want to know if it's infectious, if there is a vaccine available, and how long they need to take the tablets.

If they don't get the information they need—or feel that they need—then patients worry. If they don't understand the information they're given they worry. If they forget what they've been told they worry.

Doctors in practice just aren't capable of coping with the enormous thirst for information. They don't have the time to provide explanations in depth and most of them aren't skilled at communicating complicated technical information to untrained, worried individuals. The media's role is to turn incomprehensible technical jargon into easily understandable English.

The second role of the media is to educate. Teaching people about health has always been considered important. Back in the days of traditional Greek medicine Hippocrates spent much of his time teaching people the importance of eating carefully and exercising regularly. During the Renaissance the remarkable Paracelsus toured the lecture halls of Europe. These days most doctors are pretty terrible at educating people. They are usually clumsy, dull, boring and ineffective.

The final role of the media is to watch new developments, to assess the value of new discoveries and new commercial products and to keep a critical watch on all those practising medicine or health care—whether they are orthodox doctors or alternative therapists.

All fairly straightforward.

So why is media medicine so badly done?

Simple.

Most of the doctors who dabble in media medicine are amateurs and it shows. Some are simply keen on getting publicity for themselves. Some writers and broadcasters want to boast about their clever new discoveries. Many 'oversell' their discoveries and raise false hopes among patients. Lots work for pin money and never worry about getting proper contracts. There are hundreds of them around.

If you get the impression that I have a fair amount of contempt for the majority of 'media doctors' then you're right. I'd have the same amount of contempt for a dermatologist who decided that he'd try a bit of transplant surgery in his evenings off.

Vanity, opportunism and ignorance of the way the media works means that our newspapers (particularly the unpopulars) and our TV screens are constantly filled with misleading reports. The facts are distorted and the truth is buried. The result is that millions of patients are confused and bewildered.

I've been writing about medicine professionally for twenty years. I've written 45 books (which have been translated into 14 languages and sold in over 50 countries) and around 5,000 newspaper and magazine articles. In an average sort of week I have 20 million readers and 30,000 people ring my Telephone Doctor lines for advice. But I still work at what I do. I have one of the biggest private medical libraries in Britain. I research every piece I write with obsessive care and caution. I rewrite and then rewrite again.

I started at the bottom: writing for the broadsheet papers. The unpopulars. I was writing stuff for the *Guardian* before I even got to medical school. I was writing for the *Daily Telegraph*, *The Sunday Times*, the *Observer* and all the other so called 'posh' papers when I was a kid.

This will probably surprise you.

Most punters who don't understand the media assume that writing for the broadsheets is difficult. It isn't. It's easy. When you write for a posh paper you can spread yourself out. And you're pretty safe because not too many people will read what you write.

It's writing for the tabloids that is difficult. Writing about complex medical issues in a readable, entertaining way and being accurate is probably more difficult than you think it is.

If you still doubt me ask yourself why writers who work for the tabloids get paid around ten times as much as writers for the unpopulars. There are hundreds of doctors in Britain who'd love my job and who'd do it for nothing. Readers make writing worthwhile. Having a lot of readers makes it really worthwhile.

I'm telling you all this in the hope that one or two doctors might be persuaded to take up media medicine as a speciality.

Newspapers and TV stations need writers and broadcasters who understand medicine, who can write about health issues without distorting the facts, without bowing to commercial prejudices and without forgetting the fears, hopes and needs of those who read and listen to their advice.

It's a responsible job. I'm constantly aware of the fact that I have the biggest medical practice in Britain—and probably in Europe. *The Sun* has more readers than any other English language daily in the world. In addition I write a syndicated column which goes around the world. I'm well aware that people take what I write seriously and that getting the facts right is important. I have to keep my files and library constantly updated. And I have to put up with the fact that because I work for a popular and controversial newspaper I get attacked, and misquoted by people who feel that their interests are threatened.

But it's a great way to earn a living.

No one ever tells me what to say. No one tells me I must support this or I must oppose that. I enjoy a professional freedom that is probably unmatched anywhere in the world. My campaigns attract complaints from the establishment but my mail from readers (including doctors outside the establishment) is almost universally supportive. I get heaps of advice and information from within the medical profession.

The strange thing is that I never planned it this way. I never deliberately set out to become a media doctor. I started writing about medicine because I was angry about injustices and about the way that patients were given half truths.

I am, I suppose, successful. I probably earn more than any other doctor in Britain. But I didn't set out with that intention. I started out in this business because I felt passionate enough about things to want to change them.

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Guy's Hospital—250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.50, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

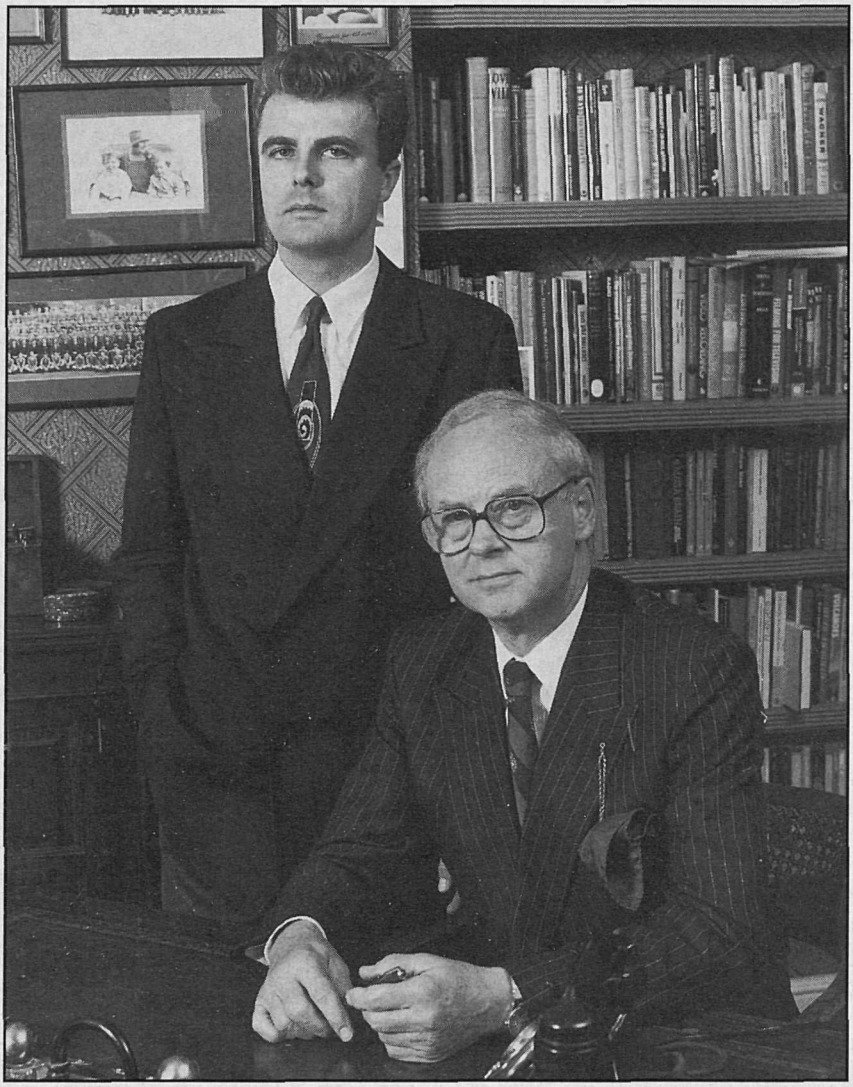
Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital—250 Years, Guy's Gazette, Boland House, London SE1 9RT.

Sir William Gull and Jack the Ripper

Dr Watts and the gory details

The morbid curiosity aroused by violent death is strangely persistent. When I first wrote about Sir William Gull the major response from those I met around the hospital was to be quizzed about his possible involvement as Jack the Ripper. I replied that it was a pointless topic for speculation unless there was something tangible to say. As chance would have it, in August, ITV's *Crime Monthly* programme, fronted by Paul Ross and ex-police commissioner, Brian Worth, OBE, chose to devote a programme to this very subject. Informative beyond the usual scope of such documentaries, this not only cleared Gull beyond all reasonable doubt but identified with fair certainty the true culprit. In so doing they reduced to its true level the best-seller combination of violent death, sordid sex, the royal family and their consultant physician, religion and a secret society! As entertainment the ingredients are perfect, particularly when portrayed by Michael Caine who stars in the latest of a long line of Ripper reconstructions. This, however, is no excuse for the character assassination of any individual let alone of one so meritorious as Sir William Gull.

The five Ripper murders took place in the autumn of 1888 around Whitechapel (near Aldgate East tube station), at that time an area of abject poverty where the prostitutes fought to preserve their pitches and scrape together enough for a bed or a main meal of bread in salt water. The first victim, Polly Nicholls, had been thrown out of a doss house at 2.30 in the morning for failing to muster the necessary fourpence; that failure cost her life. A victim of opportunity, she was almost decapitated with throat slit from ear to ear and savaged with the Ripper's hallmark of a deep slash from ribs to pelvis. This was real, not a murky, empty film set, and a moments thought (not made in the programme) brings home the impossibility of a 72-year old physician, already suffering from heart trouble and manifestly overdressed by Whitechapel standards, prowling around unobserved in the early hours of the morning in the faint hope of committing undetected so foul a deed.



Paul Ross (standing) and ex-police commissioner Brian Worth OBE who, with the ITV team of Crime Monthly and editor, Jeff Pope, finally absolved Sir William Gull from all connections with the Jack the Ripper murders and identified the true killer. Photograph courtesy of London Weekend Television Ltd.

Gull was never on the police short list and evidence for his supposed involvement was said to stem from an article in the *Criminologist* magazine, in 1970, by a Dr Thomas Stowell who claimed to find evidence among Gull's papers. The royal link emerged from the fertile brain of author Stephen Knight who suggested that Queen Victoria's grandson, Prince Albert Victor, who later became Duke of Clarence, was implicated on the grounds of having a son by one of the victims and this was known to her immediate associates who became the other victims. The Ripper was conjured-up to cover the murder of the prostitutes and protect the duke. How Prince Albert could make such an unsavoury connection is not explained but, anyway, he was out of London at the time of the murders. Thus we can see how Sir William Gull, a self-made man from a low background with no upper-class family to offend but a physician and, therefore, 'confidente' to the royal family, became the ideal fall guy. The fiction was embroidered by a fantasy contributed by Joseph Sickert who claimed, but later retracted, that his father, Sir Walter Sickert, had been involved in the suppression of the truth by a Masonic conspiracy.

The medical theory gained impetus with the discovery of what is believed to be the murder weapon, dramatically produced on ITV by Don Rumbelow, author of *The Complete Jack the Ripper*. This is a surgeons amputation knife, genuine nineteenth century, with a 9–inch blade and thumb grip. Probably used for all the murders, it had originally been preserved together with another knife in a box (later destroyed) with a heavily bloodstained, blue silk lining. Subsequently, the knife, after a mundane existence as a gardening impliment, had broken but had somehow come into the possession of Hugh Pollard, and advisor to Scotland Yard in the 1930's, and so had been preserved. Four of the victims had been examined at the time of the murder by Dr Thomas Bond to assess possible medical involvement; he recorded that the murderer had no surgical or anatomical knowledge and not even the technical knowledge of a butcher or horse slaughterer. Such condemnation may seem exoneration enough for any medical man but the lay failure to distinguish between the practical skills of physicians and surgeons, let alone the possibility of any intention to deceive, was not examined. The nature of the wounds does suggest that, unlike Gull must have been, the murderer was both physically active and quick in his movements.

The knife, then, was a red herring and the case against Gull was dismissed without even considering the significance of the possible violation of his Hippocratic oath, and attention focussed on the probable culprit. It then became apparent that it was the strength of some new evidence, discovered in 1987 by the grandson of the police commissioner, Donald

Swanson, who worked on the case at the time, that exonerates all other suspects. Notes authenticated by ITV as having been written by Swanson in the margins of a book by Sir Robert Anderson, a contemporary also involved in the murders, indicate that the murderer was a Polish Jew who unequivocally had been recognised by another Jew in the course of committing one of the murders. Both Anderson and another senior official, Sir Melville McNaughton, had also implicated, on the basis of privileged information, a Polish Jew. The latter named one Aaron Kosminsky as one of three possible suspects.

Detective work by the ITV team established the witness as Israel Schwartz who saw the third victim, Elizabeth Stride, struggling with her killer just before the murder took place. Schwartz is said to have identified Kosminsky at a special meeting secretly arranged at a police rest home in Brighton. As might be predicted, Kosminsky turns out to be an uninteresting, mentally unstable character given to filthy habits not out of place in the Whitechapel environment and with a hatred of prostitutes. Before becoming a drop-out Kosminsky had been a barber, suggesting a possible barber-surgeon derivation for his possession of the murder weapon, although this was not mentioned. Schwartz emerges as an upright character who would not give evidence against his fellow Jew probably from the fear of stimulating widespread anti-semitism in London. Particularly so, on view of the unrest prevailing at the time as a result of attacks on Jews in Czarist Russia, as well as his concern over a reaction to the fear and horror of the Ripper murders by the Londoners themselves. Following the identification in Brighton the murders stopped but Kosminsky was to spend most of his few remaining years in Colney Hatch mental asylum (now Friern Hospital, a fine Victorian edifice currently being phased out), whose records substantiate his guilt. He died of gangrene of the leg in another asylum in Leaveden.

Few murders in London escaped detection at this time and the police emerge as having identified Jack the Ripper but prudently having withheld his name. Certainly Scotland Yard could not have envisaged the wild speculation Britain's first serial killing would engender in later years. It is a pleasant coincidence that Sir William Gull should have been publically cleared of such a scurrilous accusation in the centenary year of his death. However, the story of Jack the Ripper is too good to squander simply in the interests of truth and for years to come both Gull and the Duke of Clarence are most likely to be remembered by the public for what they didn't do! Perhaps, one day, ITV would like to take a look at Gull's real contribution to medicine. It would make an almost equally fascinating programme.

D C Watts

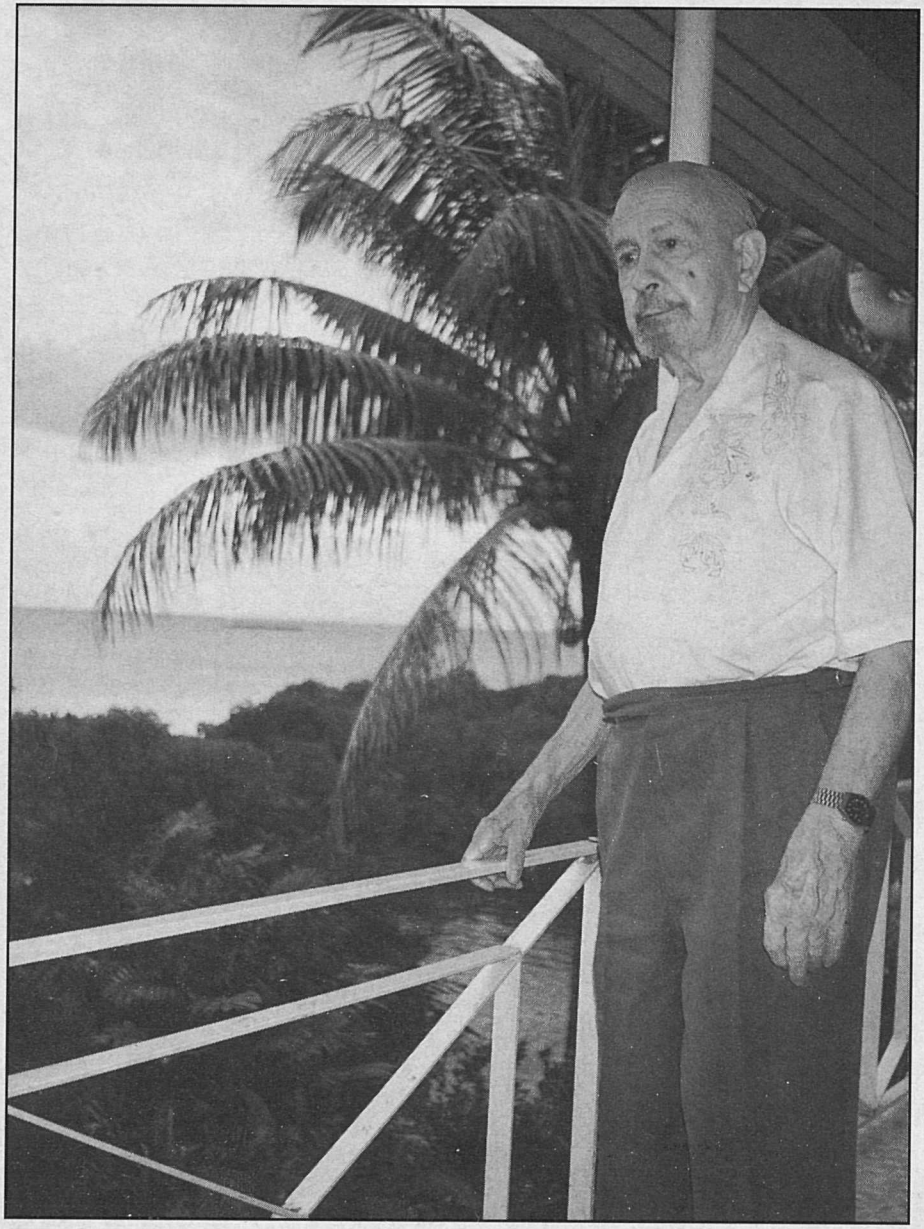
An Englishman Abroad

Mark Slade interviews Mr Ken Gilchrist

If there were a prize for the most distant subscriber to the *Guy's Gazette*, it would surely go to Mr Ken Gilchrist, a Guy's surgeon who has for 41 out of the last 44 years lived in Fiji. Now in retirement from his 34 years in the Colonial Medical Service, Ken Gilchrist lives in a house overlooking the beautiful bay at Lami, a few miles from the Fijian capital of Suva. When Martin Sadler and I knew that we would be spending our student electives in Fiji, I wrote to Mr Gilchrist, and he was kind enough not only to offer us plenty of helpful advice about Fiji, but also to invite us to his house, where we met him for dinner. It was then that we learnt of his fascinating life—as a student at Guy's in the 1920s and 1930s, circumnavigating the world as a ship's surgeon and then working for the Crown in Gibraltar, Nigeria and Fiji. The diversity of his surgical work must surely make him one of the most experienced general surgeons in the world. He has notebooks detailing over 13,700 operations that he has performed encompassing all branches of surgery.

Mr Gilchrist graduated from Guy's with the conjoint degree of LRCP, MRCS in 1932 followed by MBBS. He painted a very different picture of student life from the one which we would recognize today—of the famous rugby players who could continue to study at Guy's almost indefinitely without passing any exams; of the huge student rags, involving pitched battles between rival medical schools, fought with bags of flour and the entire stock from several fruit-barrows, with fire engines and police out in force, and of 'Minor Ops' lists, many of which were carried out by medical students under the supervision of the house surgeon!

While medical students today may worry about the risk of contracting hepatitis B or HIV from patients, in the pre-antibiotic days of the 1930s the perils of being a medical student were legion. A close colleague died of septicaemia after pricking his finger while changing a bladder dressing, while another fell victim to diphtheria. Mr Gilchrist, however, managed to survive his student days, and after house jobs became a junior staff anaesthetist at Guy's, an appointment that was to stand him in good stead for his later work as a backwoods surgeon. As this post came to an end, he was fortunate to hear of a position as a ship's surgeon on the SS Port Brisbane, a cargo ship that was sailing non-stop from London to Melbourne,



Mr Ken Gilchrist on the balcony of his house

and then back to London round Cape Horn. During the voyage his most challenging medical task was to save three pedigree red setters from an attack of distemper, but he thoroughly recommends a spell as a ship's doctor for any surgeon with a taste for something different.

Upon returning to England, Ken's next priority was to get his FRCS, which he successfully achieved a year later. Now armed with a specialist qualification, he found it surprisingly difficult to find the sort of job he wanted, and he resolved to join the Royal Navy as a surgeon lieutenant. On the morning after his acceptance by the navy, however, he saw a vacancy in the *BMJ*: 'Wanted urgently in Gibraltar, Medical Officer with surgical experience, Colonial Medical Service'. He sped to the colonial office and was offered the job, when he had to explain the difficulty of his having joined the navy the previous day. After some hurried telephone conversations between the Colonial Office and the Admiralty he was released from his obligation to the navy, making him surely one of the shortest-serving officers in that service.

Ken Gilchrist spent ten years in Gibraltar, from 1936–46, a period which of course included both the Spanish Civil War and the Second World War. At the outbreak of the Civil War a number of casualties from both sides made their way across the border from Spain into the colony, and were treated. In addition to learning to cope with military casualties, Mr Gilchrist had also to learn the intricacies of naval etiquette, since he was a frequent dinner guest on the warships in port. The unspoken rules of behaviour at the captain's table hold many traps for the uninitiated—it was not done, for example, to mention a lady's name at the table, and the direction in which the port had to be passed was not always clear. Should the unfortunate guest commit a *faux pas*, his host was obliged to stand a round of port for the whole room, which might be sixty glasses.

During the Second World War he was categorised by the Military as 'Civil Surgeon to the Fathers of Gibraltar' with status of lieutenant-colonel. After the war Ken Gilchrist was transferred to Fiji, as its first official surgeon specialist but quickly moved from there to northern Nigeria, where he was the only surgeon specialist, responsible for 370 surgical beds in the hospital in Kano, and where his catchment area included a population of seven million.

'Being predominantly Moslem the hospital was divided by a high brick wall into two virtually independent halves, one for males, the other for women and children. No male staff entered the women's half except for doctors and anaesthetists, and no female nurses entered the male half. It was a great relief to find that the Moslem women did not mind being examined by me, particularly since a great deal of the surgery was

gynaecological. The medical staff of this hospital of 750 beds consisted of myself, a European physician, a native medical practitioner, a radiographer, two white sisters and the nursing staff (all local Moslems).'

In addition to the problem of serious static electricity build-up in the hot, dry theatres, Mr Gilchrist had to deal with less expected operating hazards. 'Visiting Emirs, perhaps from Katsina, Sokoto or Maiduguri, might walk into theatre for their own amusement and poke fingers around the instruments. The Emir of Kano had his own personal beggar, a scruffy fellow dressed in dirty animal skins. He might come into the theatre demanding alms, and because the Emir had to be treated with considerable tact we had to try to find sixpence to get rid of him. On the rare occasions when the Emir would visit the hospital to be treated by me, all the staff, who were almost entirely Moslem, would fall flat on their faces. He would come into my office, where my head nurse, acting as interpreter, would lie flat on his face on the floor, raising his head to put and answer questions and then banging it down again. I asked the Emir once how many wives (including concubines of course) he had—he was uncertain, about 250 he thought!'

There were also sometimes communication difficulties in Nigeria. 'My home was two miles outside the Old Walled City in which the hospital was situated. Often in the evening I would telephone the hospital to check on the progress of a particularly sick patient. The conversation would not uncommonly run like this:

"This is Dr Gilchrist. How is patient . . . "

"No, Sir, he not here"

"No, this **is** Dr Gilchrist"

"No, Sir, he not here"

"I **am** Dr Gilchrist" (long interval, then . . .)

"Hold on, Sir, I go see . . .

no, Sir, he gone home"

The result was a four mile drive into hospital.'

Upon his return to Fiji in 1952, Mr Gilchrist worked in the Colonial War Memorial Hospital in Suva, where he trained many of the surgeons now practising in Fiji. After a few years he allowed his love of teaching to get the better of his love of the practice of surgery, and he moved to the Fiji School of Medicine, then known as the Central Medical School of the South Pacific, where he taught anatomy, histology and surgery to successive medical students, becoming, in due course, principal of the school. He received his OBE in 1969, and finally retired from the Colonial Medical Service, and his job at the FSM, in 1970, a few months before Fiji became independent from Great Britain.

One of the benefits of life in the Colonial Medical Service was the entitlement, every 2–3 years, to a period of 3 months home leave. From Fiji this inevitably involved a journey halfway round the world, so Ken Gilchrist has had the good fortune to travel right round the globe five times, by five different routes, at the expense of the Crown. On the last of these journeys, he decided to look for a place to retire. Since he was unmarried, and had no surviving close relatives, he had a free hand. 'I looked around England a bit, and Malta, Gibraltar, Canada, Bahamas, Bermuda, Australia, New Zealand and so on. I still hadn't found anywhere I really wanted to live when I returned to Fiji, to the small house I had in Lami. I had bought another plot of land in another part of Suva with the idea that I might one day build a house on it for my retirement, but in the end I thought, "I like Lami, I'll stay here". So I sold the plot and my old house and bought this one, overlooking the bay'. There are not many of us who can say that we have chosen our abode on the basis of a careful search around the world.

Many men might have been tempted to fall into a certain lassitude after such a busy and eventful working life, but laziness, I imagine, has never been part of Ken Gilchrist's make-up. On his retirement he developed an interest in Fijian modern and fossil shells, and, with the assistance of local schoolchildren, he built up very extensive collections of each, both carefully and scientifically catalogued.

In due course, having a fairly comprehensive collection of modern Fijian and overseas seashells and probably the world's biggest collection of Fijian fossil shells, he felt it time to dispose of them. The modern collection was donated to the Smithsonian Institution, Washington (catalogued and packed in 13 large drums, filled weight about 70 lbs each, by one of their young scientists, all transported at their expense by air). The Fiji fossil shell collection was donated to the Australian Museum, Sydney, which particularly wanted them.

Nowadays, at 80, Ken Gilchrist's days are spent relatively quietly, shopping in Suva and playing snooker with old friends at the Fiji Club, a splendid place, highly reminiscent of the days of the Empire, where he was kind enough to make Martin and me honorary members for the duration of our stay. He remembers Guy's with much affection, although the last time he visited it the Tower was only half built. I feel sure that if any Guy's students are planning an elective in Fiji next year, he would be very pleased to see them.

Professor Roger Robinson

An Appreciation

Roger Robinson was appointed to the then newly-founded Ferdinand James de Rothschild Chair of Paediatrics in 1975, when it was in the Medical School of Guy's Hospital, and retired from it on 30 September 1990, by which time it had become the UMDS Chair of Paediatrics following the merger of the previously separate Schools of Guy's and St Thomas's Hospitals. He brought to the new appointment a distinguished academic and clinical record.

From Poole Grammar School he went up to Balliol where he was Brackenbury Scholar and took a first in Physiology. His undergraduate career and his subsequent appointment as Lecturer of Christ Church, Oxford were marked by numerous honours and distinctions: he was successively War Memorial Student of Balliol College, Theodore Williams Scholar in Physiology and Christopher Welch Scholar in Biology. The culmination of this phase of his career was the Rolleston Memorial Prize for his D.Phil. thesis. Any suggestion that he achieved these honours by being merely an inky-fingered swot is effectively countered by the fact that, as Captain of Boats, he succeeded in his spare time in taking Balliol to head of the river.

His subsequent career was equally distinguished. Following clinical training at the Radcliffe Infirmary, where he was Medical Clinical Scholar, he was House Officer and Senior House Officer at the Radcliffe Infirmary, the Hammersmith Hospital and the National Hospital, Queen Square before embarking upon a long and productive period in the Department of Child Health at the Hammersmith where he rose from House Physician to Senior Lecturer and Honorary Consultant Paediatrician. Within this period of almost ten years he spent a year as Fellow in Neurology at Harvard followed by an appointment as Visiting Lecturer to the University of Kentucky Medical Center, Lexington, Kentucky. He conducted clinical and basic research in several fields, leading to the publication of a series of papers of which several are recognised as landmarks, especially those dealing with the development of the nervous system and neurological behaviour in infancy. The promise of the Rolleston Prize is realised in these writings which, as well as good science, are models of lucidity and elegance of style.

He came to Guy's as Consultant Paediatrician and Paediatric Neurologist in 1971 and 1973 was appointed Director of the Department of Paediatrics, in which capacity he undertook responsibility for student teaching. This led naturally to his appointment to the Chair four years later. Throughout his entire period as Director and Professor he gave the highest priority to the student teaching programme, recognising that this is one of the two primary responsibilities of an undergraduate teaching hospital, the other being patient care. His success in this respect is attested to by feedback from firm after firm of students, who invariably expressed high appreciation of his personal teaching and satisfaction with the course as a whole, the organisation of which has evolved by successive refinements from his original format established in the 1970's.

From 1969 to 1982 he was editor of the *Archives of Disease in Childhood*, the leading British journal of Paediatrics. This was an onerous task indeed, and under his editorship the journal doubled its publication rate from six to twelve issues per year. It is largely as a result of Roger's efforts that the *Archives* enjoys the status it does today as one of the major international organs for both basic and clinical research in Paediatrics and related disciplines: a recent issue (October 1990) contains original papers from ten countries. A more comprehensive account of his contribution to the *Archives* was written by Roy Meadow and published as an editorial in May 1982[1]. As if his duties as clinician, Professor and editor were not enough he found the time and energy to sit on numerous hospital, University and national committees and working-parties, to all of which he contributed with his usual throroughness and distinction.

He preserved his almost impossibly high personal standards throughout his professional career. A few years ago he wrote of himself: "I am somewhat obsessional in the standard of work that I try to maintain'. Those who know him will recognise in this two things: first, the accuracy and honesty of the statement and second, the insight into his own and other people's personalities, both characteristic of the man. To these attributes are added many others, including tact and sensitivity in his dealings with others: his own severest critic, he has always tempered justice with mercy in his comments on the performance and behaviour of his colleagues, for which many of us are (or should be) grateful. The same combination of critical intelligence and kindness makes him an outstanding communicator with patients. All doctors have to transmit bad news to patients and their relatives from time to time but this sad duty falls to the lot of the Paediatric Neurologist more often than to most, both in respect of his own patients and when acting as a consultant to a colleague's patient in the intensive care unit. Roger's ability in this respect

is unsurpassed in my experience, both in terms of the reliability of the clinical opinion arrived at and the manner in which it is given to the devastated parents. In less extreme circumstances he is able to refine and simplify (but never over-simplify) a complex problem in general paediatrics or paediatric neurology in such a way as to make it intelligible not only to the patient and his relatives but even to a Nephrologist.

Roger was and is a charming man and an exemplary colleague. His high intelligence and rigorous logic, coupled with a quiet manner which could be mistaken for diffidence, give an impression of slight remoteness at first meeting but this is misleading. He has many interests outside medicine, including gardening, canoeing, music, reading in many spheres and walking. He also has a ready sense of humour and a total absence of pomposity or self-importance: I have seen him reduced to helpless laughter at the sight of a student at a firm party giving a brilliant and hilarious imitation of himself in his outpatient clinic. He will be greatly missed at Guy's for his wisdom, his intelligence, his total honesty, his leadership and simply the pleasure of his company. We wish him a long, productive and enjoyable retirement.

George B. Haycock
Professor of Paediatrics

Reference

(1) Meadow R. 'an editor departs'—Editorial—*Arch Dis Ch* (1982) **57**, 325

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Oxford Handbook of Clinical Surgery. G R McLatchie, First Edition, pp 878, soft cover. Price £12 95

I am not a great fan of the pocket-sized textbooks that fit the 'white coat pocket' but this is yet another book aimed at this market, presumably to compliment its medical counterpart. As such it is well laid out and, as the author says, it provides a succinct account of current surgical practice and general operative surgery. The book is essentially divided into four parts: an introduction; general surgical problems; systematic surgery, and finally a collection of chapters consisting of hints for the housemen, anatomy and operative surgery. Throughout the book there are blank pages for the student to make personal notes.

What I think is too ambitious, and probably to the detriment of the book, is that the author has aimed if at medical students, housemen and surgical trainees. Presumably the section on anatomy and operative surgery is the part directed at trainees, and as such is not detailed enough for the Fellowship examination. Similarly, in this section the choice of illustrative diagrams is unusual. For example, there is a whole page (787) of diagrams illustrating the reconstruction of a breast using a latissimus dorsi flap, but in the vascular section no diagram relating to exposure of the carotid, aorta or femoral arteries.

In a book covering the whole of surgery one is unlikely to agree with all the contents but in some sections the text was out of date, or incorrect. For example, rigid oesophagoscopy for injection of varices has been superceded by flexible oesophagoscopy, ultrasound *is* the investigation of choice in biliary disease, vasodilator drugs offer *no* benefit in peripheral vascular disease and a white cell count in appendicitis is *not* a useful sign. Also in the list of causes of pancreatitis no menton is made of cytotoxic drugs or azathioprine, but the scorpion gets a mention!—useful if you're revising in Trinidad on an elective.

I was also concerned in the section on hints for the housemen that advice was being given on how to insert CVP lines, do a sigmoidoscopy, even an upper GI endoscopy. These techniques are all ones that should be taught under direct supervision and once learnt do not need a pocket book as a reminder.

In conclusion, this book will have its widest readership amongst medical students, and as such provides an overview of surgical practice, that can be referred to, if the need arises, from the coat pocket. It can only be recommended for this use and I would not recommend the surgical trainee to use the book or a houseman unless a copy was bought as a student.

A R Hedges

Principles and Practice of Surgery. Eds. A P M Forrest, D C Carter & I B Macleod, Churchill Livingstone, 2nd edition, soft cover. Price £24.95.

This is the second edition of a textbook that was initially written as a surgical companion to *Davidson's Principles and Practice of Medicine*. It has evolved considerably with many new entries and two new chapters. Despite this it remains about the same length as the previous edition, and retains the characteristics of being easy to read and well illustrated.

I particularly liked the chapters on fluid and electrolyte balance which provide a clear and concise explanation of surgical practice, a topic that students seem to find difficult to grasp. There should be no excuse now for students not being able to comment on the quantity and electrolyte content of intestinal secretions.

The section on thromboembolic disease was particularly refreshing. For the first time I know this textbook clears the air regarding the contraceptive pill and surgery. It seems pointless to stop the 'pill' when the risk of developing a DVT from a subsequent pregnancy is greater than that of surgery with low dose heparin cover while continuing the contraceptive. I know that this has been reported in journals but it is refreshing to see dogma removed from textbooks. Similarly, the use of subcutaneous heparin (in doses of 250 units/kg bd) in the treatment of DVT is described. This has been my practice for several years, based on personal research work, but the message has got into this book. In keeping the text up to date the authors mention the use of low molecular weight heparin, which is highly commendable as the drug is not yet generally available.

Principles and Practice of Surgery has developed into an admirable textbook, which is easy to read and digest. This book can be highly recommended as the definitive textbook for undergraduate surgery.

A R Hedges

Talking With Patients. Myerscough, OUP, first edition. Price £10.50

This book is intended for medical students but should be required reading for students in other health service disciplines. It has been carefully planned and covers all aspects of doctor-patient interviews, including physical examination and clerking. There are specialist chapters on patients of different ages, on sexuality, dying and the influence of culture on communicaton.

It is beautifully written, concise, mercifully devoid of jargon and always related to the clinical task. It will be the course book for the UMDS Advanced Communications Course.

Bernie Rosen

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State of the Union Address

This column has been absent from the Gazette for far too long. I must, therefore, begin by apologising for its absence and hope that readers have not been inconvenienced by the lack of union news.

Anyway, we are back and wish you all a happy and prosperous new year. This new year brings with it many exciting possibilities for students at Guy's and St Thomas'. We are now working together on all student activities and hope to provide more and better services for the student body by pooling our resources.

Last year saw the first year of full Guys and St Thomas' integration. On the whole all events were successful and were well supported.

The Guys side of things has seen the refurbishment of Boland House—the Bar, the Spit and all of the first floor function rooms. The Bar is busier than ever before and it seems to have attracted a wider clientele, as well as the usual hard core.

With both the Vice-President and Bar Secretary away on elective Huw Morris and Andy Klein have deputised. They have both done marvellous jobs. In particular, Andy Klein must be commended for his work in setting up the bar and starting it off on the right foot.

We now have our own T shirt printing facilities and hope that they will be used by all organisations and clubs.

We are also in the process of planning, this years charities week and welcome interested second and third years to join the organising committee. The funding for a minibus for club use has been raised and this will be purchased in the near future. Plans are also underway for a development of the Party Gymn. I would welcome comments on this from all interested parties.

If at anytime you feel the Clubs Union can help you please do contact any Union Officer at Boland House.

God Bless you in the New Year

Richard Russell
Clubs Union President

What is SMEC?

The Student Medical Education Committee (SMEC) is a voice for medical students in the running of medical studies. This article outlines some of its aims and the participation required by students to make it work.

How did SMEC arise?

SMEC has been in existence since the 1960's. Until 1989 it met regularly at Guy's and consisted of an elected council with at least one representative from each year. Following the full merger of the pre-clinical years at Guy's and St Thomas' it was inactive, but in September 1990 it was resurrected as the UMDS SMEC under the chairmanship of Charles Phillips, a fourth year student at St Thomas'.

Why is SMEC important?

There are a number of reasons why a coherent student opinion on the medical course is likely to be effective at the moment. Firstly, many changes will be needed to remove the differences between Guy's and St Thomas' clinical courses. For example, the rank order

sign-up system, long a bone of contention amongst students at Guy's, doesn't exist at St. Thomas' where house jobs are allocated on the basis of an interview and a reference. The evolution of a new system provides an ideal opportunity for students to influence a move towards a fairer arrangement.

A major overhaul of the medical curriculum is planned which will take effect from October 1992. Possible changes include: bringing forward Obs and Gynae finals to the fourth year; more integration between clinical and preclinical courses and the introduction of new subjects such as law and health service management. The clinical dean, Professor Chantler, is keen that SMEC provides a forum for any proposals from students and feels that surveys carried out by SMEC of student opinion would be an extremely helpful way both to direct, and to test, the acceptability of the new course. Representatives of SMEC, will sit on the main steering committee for the new curriculum and on each of the subject committees.

Another change in the pipeline will radically alter the way in which all university teaching takes place. The Committee of Vice-Chancellors and Principals (CVCP) have introduced formal assessment of the quality and appropriateness of university teaching in the form of 'Academic Audit'. This audit involves heads of department producing regular reviews of their courses, and presumably this will mean more in-course testing of knowledge and more feed-back from students.

Lastly the NHS in general, and Guy's in particular, is entering an uncertain period with the introduction of the new NHS bill changes—Guy's becomes a self-governing trust from April 1st 1991. It is surely partly the responsibility of the students to ensure that undergraduate and postgraduate education maintains some sort of priority amidst the invoices and balance sheets.

Will SMEC have any influence?

SMEC reports directly to the Education Committee, whose members include the principal and pre-clinical, clinical and post-graduate deans. SMEC has the power to invite any member of staff to a meeting and in the past this has usually involved inviting heads of department along to discuss current departmental policy and possible areas for improvement. Future course questionaires will be organised (with the co-operation of heads of department) which will allow possible areas for change to be targeted. As outlined above, there seems to be a trend towards a more serious adoption of student views in the overall running of the medical course. It may not yet be a buyer's market, but it seems that consumerism is even having an effect in the paternalistic world of medical education.

What can I do?

More people are needed to attend the committee—ideally at least two representatives from each year. The next meeting of SMEC will be publicised in a few weeks time and is open for anyone to attend—if we are swamped with members then we will hold a ballot for elected representatives from each year. If you're not interested in attending the meetings themselves, SMEC welcomes any suggestions as to how the course can be changed and improved—please put any ideas in writing to your current year representatives (anonomously if

wished). Finally, SMEC will be distributing questionaires to each year group—the higher the questionaire return rate the more authoritative the results will be—so please complete yours.

Currently SMEC comprises: Charles Phillips (Chair); Edward McKintosh (second year); Omar Rahim (second year); Rob Bruce (third year); Jackie Briggs (third year); Fiona Miller (fourth year) and Huw Morris (fourth year). Leslie Millard, the Educational Advisor to the Medical School, also attends the meetings.

Screen Printing

The beginning of October saw the end of the use of T shirt printing companies by Guy's students wanting to publicise events. Guy's now has its very own fully operational screen printing equipment, which is available for use by all clubs union members. Situated on the first floor of Boland House, the printing press has its own room kitted out with U.V. light box, stencil developing booth, drying cupboard, pots of ink, emulsions and hundreds of wire coat hangers. The equipment will print two colours onto any item of clothing and enables designs to be converted from a black on white image onto a screen stencil which will print thousands of low cost T shirts. In addition it has the facility to print onto card so that posters and tickets can also be produced. Our first batch of one hundred T shirts was printed in October and since then we have been inundated with orders. This equipment is clearly going to be an enormous asset to the Clubs union. My thanks go to Terry Gibson, Mel Evans, Mike Fendick and Peter Frost without whose help the acquisition and installation of this equipment would not have been possible.

Clare Walford

November Dental Society Lecture

This meeting gave us two most interesting accounts of recent trips by Dr Peter Morgan of the Department of Oral Medicine and Pathology, who went to Japan to attend the fifth Meeting of the International Association of Oral Pathologists, and Mr Graham Smith, a final year dental student, who spent three weeks in Cleveland, Ohio, for his elective period.

We were very pleased to welcome a group of students visiting our School from Bergen. They seemed to enjoy themselves immensely and were keen to join us for the evening. The attendance at the meeting was very good, considering that this was right in the middle of examinations for many of our students, including the entire final year.

Graham Smith started the evening with a well illustrated talk. He travelled to the States as part of a student elective exchange with Cleveland dental student, Lisa Galici. Lisa had spent three weeks in the UK a little earlier and then Graham stayed with her family for his elective. He obviously enjoyed his trip and spent a lot of time in the Dental Hospital; he also discovered many differences in dental education in the United States. For example Schools are either state or private and it costs approximately, $90,000 to qualify at the latter but each student has his own chair for the entire course. I could hear a number of our students muttering 'I'll Share'.

Graham was, I'm sure, a very good ambassador for our School and finished his trip with a few days sight seeing in Washington, during which time he visited the Bethesda Naval Hospital (literally the day after most of the staff had been transferred to the Gulf).

Dr Morgan entitled his talk a 'Do's and Don't Guide of Japan'. He was considering the possibility of electives for Guy's students in Japan and he made some very positive contacts in that respect.

Besides attending the Oral Pathology Conference he travelled widely throughout Japan using the ultra-fast Bullet Train. He was obviously captivated by the country and its neatness and attention to detail—litter just does not exist.

Dental education in Japan is very different from that in the UK. There are 29 Schools of which about half are private. The course is six years long and students only start clinical work in their final year. Dr Morgan discovered one embarrassing 'don't' when he blew his nose in a restaurant and the waitress burst into fits of giggles. This is definitely not done! A few more helpful tips were given to prospective elective students to ease their path through this fascinating country.

A very enjoyable evening finished with a pleasant reception courtesy of the Medical Defence Union.

Lyndon Cabot

Cosmetic Dentistry

Our President, Professor Rowe, introduced our Speaker to a near capacity audience, including a large final year contingent hopeful of picking up a few snippets of information to help with their impending final examinations.

Mr Dewe Matthews had in fact been one of Professor Rowe's students about twenty years ago and it was at that time that his interest in occlusion began. He went on to win the Newland-Pedley prize for operative dentistry in 1972 and later, after qualifying, he obtained a Master of Science degree in advanced restorative dentistry at Ann Arbor, Michigan. He is now in practice in the West End.

Right from the beginning of this interesting and entertaining talk Mr Dewe Matthews stressed the importance

of correct diagnosis and treatment planning before any advanced restorative procedures are contemplated. He also pointed out how closely he liaises with his Periodontal colleagues in the treatment of his patients, assuring a sound foundation on which to carry out his work. Patient expectation when undertaking work of this nature is one factor that must be discussed fully to determine the probable results for a given clinical situation and he remarked that unsuccessful cases are more likely to be due to breakdown in communication and unreasonable expectation rather than a clinical problem.

The elements of full mouth restoration, including the provision of temporary restorations to promote the resolution of existing periodontal conditions were discussed as the main theme of his talk, illustrated with a large number of his clinical cases. Full arch crowns without a visible tissue reaction was the norm—The quality of his work is superb.

It was quite plain to see that a number of the more senior students were very surprised at the results achieved in some cases where the initial picture looked bleak. Mr Dewe Matthews, I'm sure, gave some cause to look again at their own clinical practice and others an idea of a level of excellence that can be achieved given the correct circumstances.

An enjoyable evening was completed with a reception courtesy of the Medical Defence Union.

Lyndon Cabot

Boat Club

University of London and United Hospitals Winter Regattas

These events were held as usual on the last two weekends of the Winter term. The Boat Club, currently at its largest size for many years, entered three mens VIIIs, four ladies VIIIs, one mixed VIII and several small boats into both regattas.

In the races, the 1st VIII was narrowly beaten in both regattas by the Barts 1st boat, who went on to win the Open Division in the University of London Regatta. A coxed IV, chosen from the 1st VIII, won through to the final of their event in the UH Regatta, against two crews from St Marys. However, UH Officials decided to send the crews off against the stream, with the Guys crew bearing the full force of the Stream. Despite this handicap, the Guy's crew was only narrowly beaten by Mary's A boat and beat Mary's B boat.

Stroke and seven from the 1st VIII were persuaded to race in a pair for the regattas. Winning their heat easily in the UL event, they raced St Thomas's in the final and lost by less than a length in a very close race.

They were unfortunately drawn against the same very accomplished pair from St Thomas's in the UH regatta, and so progressed no further in this event.

The 2nd VIII were entered into the 500 m sprint event in the UL Regatta. Despite the hour long 'pre race warm up', the crew lost by only a length to the same crew from Barts who had beaten the 1st VIII earlier.

In the UH Regatta, a four from the Freshman crew (oarsmen who had never rowed before coming to Guy's) won through the first round only to lose the final by a canvas in the closest race of the day.

I would like to thank our supporters for their encouragement.

Crews

Mens 1st VIII: J Robin, M Smith, N Galletly, J Crossman, A Cash, S Hodges, G Mclellan, C Lewis, cox Louise Ward
Mens 2nd VIII: A Mosahebi, M Secombe, Robert S Kell, R Simons, T Downes, B Kelly, A Hobkirk, cox Emma Morton
Freshman VIII: T Knight, Art, N Harrison, M Rocker, R Odling, C Muller-Pollard, C Sherwin, N Spilker, cox M Creedon.

Netball Club

Although founded just a few months ago, the Guy's and St. Thomas' Netball Club is now going from strength to strength. We have two teams and participate in the London Netball League. This involves some strenuous matches played on Wednesday afternoons and Saturdays. Practice sessions take place every Monday at 6 pm at Honor Oak Park. This training is clearly paying off since we have not lost a match since November. Having been defeated against Barts 32–2 at the beginning of the season, the same Guy's and St Thomas' team were victorious before Christmas beating them 29–24. We hope to continue along in this mode for the Hospitals' Cup which takes place at the end of March.

Clare Walford

CLASSIFIED

Birth

PENNEY—1 December to Rachel, née Lawson, and Oliver, a daughter. Present address: Raihu Health Centre, PO Box 13, Aitape, Papua New Guinea.

Deaths

FREDERICK NOEL GLOVER, formerly a surgeon at Guy's, died peacefully on 4 January. The date of a memorial service to be held in the Guy's Chapel is yet to be announced.

WILLIAM SHELDRAKE. Dr Sheldrake died on 28 December 1990, at Oxendon House Retirement Home, Northants. A proud Guy's man, medicine remained the thing closest to his heart until the end. His death was both peaceful and merciful.

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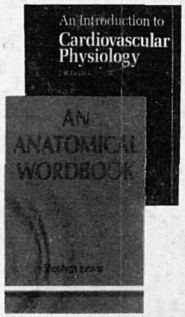

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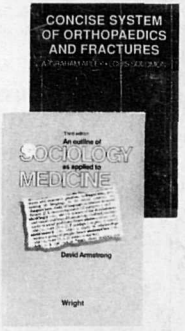

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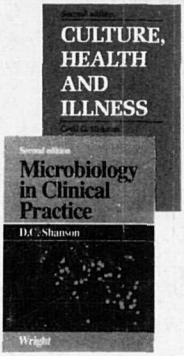

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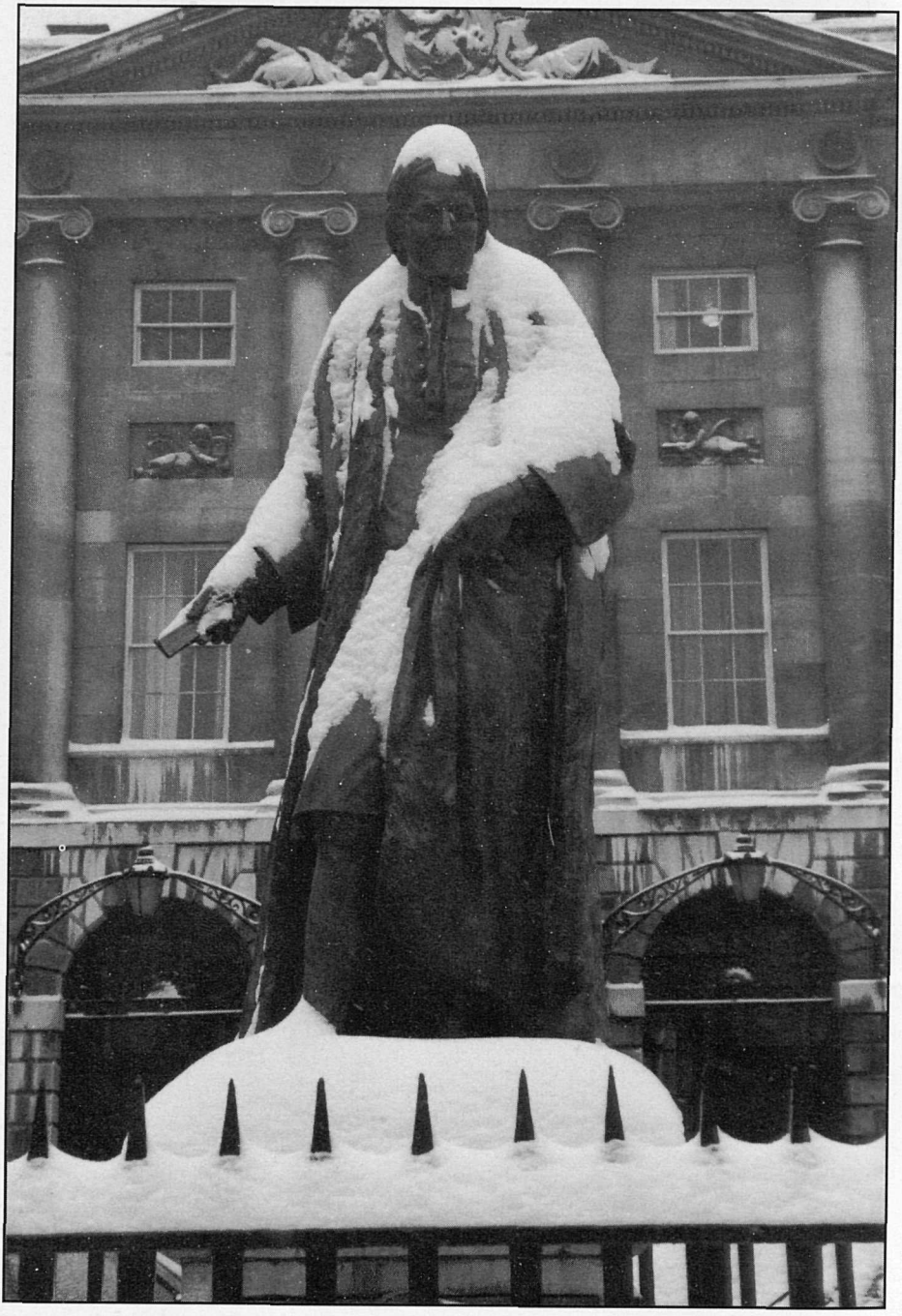

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Volume 105 Number 2410 March 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

The majority of the *Gazette* rabble are currently in the throes of the UMDS Advanced Communications Course. There is a tendency for such ideas to be greeted with cynicism: they are pointless play-acting; full of jargon and simply no substitute for experience. Why then, according to a Consumers' Association survey, do one in five patients leave a NHS out-patient department having seen a consultant, with no clear understanding of what is wrong, or what treatment they will receive?

It is difficult to blame patients for their lack of understanding. It is the doctor's role to make himself understood. It is he who is treating the patient and should be addressing himself directly to the patient's problem. Yet it is not the doctor's intention to misinform or deceive. Where, then, does the problem lie?

Dare we suggest that there should be more communications training for qualified doctors? Many medical students pronounce themselves surprised at the lack of tact and understanding that is sometimes displayed during hurried consultations. It is not enough to blame poor communication skills on time pressure.

Perhaps patients should not complain about the lack of information imparted at out-patient clinics, since a recent National Audit Office (NAO) study suggests that they were lucky even to have an appointment. It points to wide regional variations in waiting times and suggests that they could be improved with better management. For example, waiting times for a first routine appointment in general medicine ranged from five weeks in Leeds to twenty two weeks in Chester. Even after such times, many people were often kept waiting for several hours in the clinics. Some patients found their clinics cancelled due to staff sickness or holidays and in almost a quarter of clinics studied the consultant was twenty minutes late. Perhaps the reason why out-patient consultations are so rushed is because doctors are so often late.

Midwife Misery

Dear Sir,

Why does such enmity exist between midwives and medical students? Prior to beginning the obstetrics course we were advised (warned?) to treat midwives with respect and humility—this was surprising since I would hope students always behaved in this way with medical professionals or patients. But the reasons for the advice soon became obvious. Midwives harbour a terrible grudge against medical students and seem to delight in confounding our attempts to gain obstetric experience. No matter when one arrives on the ward, women in labour are almost automatically assigned to the student midwives. The reason for this discrimination, we are told, is because they have to witness and perform many more deliveries than medical students—the problem never addressed is that student midwives have a longer time in which to reach the requisite number than medical students. At present the 'practical' obstetrics and gynaecology course lasts just ten weeks, so it is not surprising if towards the end of this time that medical students' approach occasionally seems mercenary. The fact is that we are **all** students and we deserve an **equal** opportunity.

The vast majority of midwives, of course, do not behave in this way, but there are always some who have to spoil it for the rest.

Yours faithfully,

NOLAN HUNTER
Boland House

Super Spit!

Dear Sir,

What a pleasure it is to be able to write something complimentary about the Spit Dining Room. Although the furniture and surroundings remain depressingly decrepit the staff must be congratulated for their recent culinary initiative—a 'theme bar'. Last month, we were treated to a stunning selection of pastas, sauces and pizza. These were generally excellent and if you closed yours eyes really tight, blocked your ears, held your nose and had a really good imagination, you could almost have believed you were in Italy.

This month's theme is jacket potatoes—just the thing for the cold weather.

The spuds are perfectly cooked and there is a panoply of delightful toppings to choose from—my favourite being the attractive-looking spicy beef.

Well done the Spit! But it's going to be hard to maintain this standard for the year.

Yours faithfully,

N E GRUB
Boland House

1945 Dental Reunion

Dear Sir,

During the Second World War students at Guy's were evacuated to Tunbridge Wells and Pembury. The medical and dental schools were in the 'Golden Mile' along the Pembury Road, in very large houses and surrounded by extensive grounds. All the students enjoyed their stays in Kent. The quiet was often broken by the noise of planes taking part in The Battle of Britain, and we were often

drafted in as theatre orderlies at Pembury Hospital when casualties were operated on (straight from the beaches during the exacuation of Dunkirk). Many of the students were members of the Home Guard, a duty they continued in London during their clinical period, unless they were fire-watching or spotting V-1's from the highest vantage points in the hospital.

Many friendships forged during this time were forgotten as the years progressed. However, recently one group returned to visit their old digs, pubs, and their old HQ—Sherwood Park—now the home of the Area Health Authority. Many of the participants had not met for 45 years, yet little seemed to have changed.

The reunion was organised by Denis Reid and 38 dentists (who all qualified in 1945) were able to attend. Amongst the number who gathered at the Spa Hotel, Tunbridge Wells, were three special guests—the three Dental Deans who had connections with 'The Wells' namely Ron Emslie, Jack Rowe and Jack Tulley.

After dinner, John Burt showed slides of the attack on Guy's by King's, in their effort to reclaim 'Reggie', their lion mascot. Needless to say, they failed. There were also slides of the crowning of Thomas Guy, and the VE Day celebrations. In all it was a great success: friendships were renewed and a call was made to celebrate 50 years in 1995. How many will there be on that occasion?

Yours faithfully,

DENIS REID
13 Barnfield Rd
Livermead
Torquay

Below: (l to r) Prof Rowe, Denis Reid, Prof Emslie

Guy's Overspent

Guy's is overspent by £1,372,000 at the end of month eight in the financial year. This is an increase of £218,000 over the previous month's figures.

Charities Week

The first ever UMDS Charities Week will take place from 25 April to 3 May.

Last year's individual Charities Weeks raised £72,000 in total, and we hope to keep up the excellent work.

This year we have tried to find a Charity that would link both campuses, and the committee decided that supporting the children of Guy's and St Thomas' Hospitals would be a worthwhile cause. In choosing this broad spectrum of support we have included:

Evelina Children's Hospital Appeal
Evelina Children Heart Fund
Evelina Children Family Trust
Evelina Children's Heart Organisation
Special Care Baby Unit Appeal Fund
St Thomas's Baby Fund.

We hope to present the money to these charities in the form of a specific gift to each one.

In addition, we hope to give financial aid to many other local, national and international charities.

We hope that this year's combined Charities Week will prove to be as successful, and memorable, as previous Charity Weeks.

Dan Ellis
Charities Week President

Mr Alan Yates, FRCS—Thanksgiving Service

A Service of Thanksgiving for the life and work of Alan Yates, late Consultant Cardiothoracic Surgeon to Guy's Hospital, will be held in the Guy's Hospital Chapel, St Thomas Street, London SE1, on Thursday 7 March 1990 at 12.00 noon. Admission by ticket, available from the Clinical Superintendent's Office, Counting House, Guy's Hospital (Tel: 071-955-4169).

Delays and Cancellations in Children's Unit

Several kidney transplants in the Evelina Children's Unit at Guy's have been cancelled recently. Jane Kilmister, a hospital spokeswoman, said children would have to wait until bed and staff shortages were rectified.

'There are 50 children on the paediatric urology waiting list, these children don't have definite dates to come in yet.'

This was followed by news that Evelina Children's Unit faced a shortfall of £250,000 for the financial year, and may have to close wards because the Hospital has to balance its books by April.

Talks are apparently to be held between NHS officials and hospital chiefs to find ways of easing the situation at Guy's.

Hypertensive Patients 'missing out'

Up to four out of five patients with hypertension might not be receiving treatment, the Office of Health Economics suggests in a study of prescribing patterns.

The study of more than 100 practices found that the highest prescribing GP's used up to 16 times more drugs for high blood pressure than the lowest prescribers. Some practices appeared to be prescribing on average for as few as one in five patients with moderate to severe hypertension.

The report also says that low prescribing GP's treated only half as many patients with the more insidious late-onset form of diabetes mellitus as high prescribers.

The OHE is a think-tank of the Association of the British Pharmaceutical Industry.

'No Huge Pay Rises' for Managers

Trust managers should beware of awarding themselves large pay increases, William Waldegrave has warned.

He told a conference on self-governing trusts last week: 'My view of the future does not include pay spirals for those at the very top'.

The Health Secretary's warning comes as the 56 trusts begin to compete for the top managers.

Guy's and Lewisham Hospitals Trust is reported to be offering NHS deputy chief executive Peter Griffiths £90,000 to lead it from April.

Gulf Preparations

The Hospital has been notified that it should expect to take casualties in the event of serious military action in the Gulf. There could be up to 65–70 casualties per day which will be divided amongst the designated hospitals in the Region. An immediate red alert will be declared at the Hospital in the event of conflict and only emergency cases will be admitted.

Doctors and nurses at Guy's have already attended lectures and briefings on the treatment of injuries from high energy missiles and chemical weapons.

Guy's to Borrow £8.5m.

Guy's has won approval from the Department of Health to borrow £8.5 million pounds once it has adopted self-governing status. This figure is exceeded only by a group of hospitals in Bradford, which is to be given a limit of £11.4 million pounds.

The financing limits were announced by the Health Secretary. Many hospitals proposed ambitious building developments when applying for trust status and the figures will let them know how far they can go.

Between them they will spend about £30 million pounds on capital projects, £8 million pounds more than they would have received had they remained under health authority management.

Cuts in Research Grants

The Medical Research Council is predicting that hospitals will face cuts in medical research programmes due to a Government squeeze on grants for next year. The MRL grant for next year will be £700 million. This represents only 5.8 per cent increase on last year's total—and a cut in real terms.

The MRC Council met last week to discuss the crisis and is considering running down or closing more of its 50 research establishments.

Trust Ready and Waiting

At a recent management board meeting it was reported that the Guy's, Lewisham and Mental Illness Shadow Trust had been established and would be acting in its full capacity from 1 April, 1991. In addition it was announced that Professor Lessof, Mr T Ford and Mrs G Mallinson had been appointed as non-executive directors; that Mr P Griffiths, Mr P Burroughs and Dr R Stott would be executive directors and that Dr Saxton and Dr Master will also sit on the Shadow Trust Board.

Guy's Fitness Centre

The new fitness centre (situated in the basement of Shepherd's House) opened recently. The centre offers fitness assessments and individual exercise programmes for all users from fully trained staff. For more information or to arrange an informal tour, telephone extension 2402.

Guy's RFC 200 Club

The winner of the carton of wine for January 1991 is Dr E Rose of Aberdeen.

The Rugby Club welcomes new members. Bankers order forms can be obtained from Dr Gibson, Guy's Hospital, London SE1 9RT. The annual subscription is £15. During the season a draw takes place every month and each winner receives a dozen bottles of wine or the cash equivalent.

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An Optimist's View of the NHS?

An interview with the chairman of the BMA

Walking through the large archway, one enters the tranquil square at the heart of BMA House. The noise of the traffic is left far behind and the silence is broken only by the gentle tinkling of a water fountain. The scene, with its neatly manicured lawns and signs for the members' dining room, is redolent of the calm and affluence traditionally associated with the medical profession. However, the last few years have been different. The BMA has vigorously opposed the Government's reforms of the NHS. Their protests have not only taken place at ministerial level, but have also included an expensive high-profile advertising campaign. The aim of these tactics was to raise public awareness of the white paper changes and, in this respect, it seems to have been £2.5 million pounds well-spent as the last BMA/Gallup poll showed that 77 per cent of those surveyed who had heard about the NHS changes, disapproved of them.

Recently the BMA has adopted a less strident tone, and this can be attributed to a number of factors. Firstly, the NHS changes are now to be implemented against a markedly different political backdrop, following the resignation of Mrs Thatcher and the appointment of William Waldegrave as the new health secretary. Secondly, there has been a change at the top of the BMA—the new chairman is Dr Jeremy Lee-Potter. Dr Lee-Potter qualified from Guy's in 1958 and has fond memories of the hospital and of playing rugby, with a panther-like Dr Knight at scrum-half.

Dr Lee-Potter, who describes himself as 'fundamentally an optimist', is developing a more conciliatory approach in the BMA's attempts to persuade the Government to reconsider the reforms. He said: 'You can't get anywhere with a fight. You only get things done by talking.'

Some doctors have criticised the BMA for its new low-key approach and want a return to the bellicose, chest-thumping days. Indeed, Dr Lee-Potter was castigated for referring to Mr Waldegrave as 'a nice chap'. Nevertheless, Dr Lee-Potter remains adamant that a constructive policy is the only way forward, and to this end he plans to create a BMA 'think tank'. He hopes that

this group will formulate solutions to the major problems facing the NHS and then present these to the Government.

However, it is only the style—not the substance—of the BMA's opposition to the reforms that has changed.

'Our major objection to the reforms is the fragmentation of the NHS that may result. The present structure of the NHS ensures that patients receive similarly high levels of health care throughout the United Kingdom. But competition and the formation of trust hospitals could result in the creation of a few centres of excellence with relatively poor provision of care elsewhere.'

The BMA contends that it is a fallacy to consider the NHS as a genuine market, since sheer distance alone will mean that the majority of 'providers' will not be available to any one 'purchaser'. They believe that the principles of the market place cannot be applied to the health service, and that the creation of so-called internal markets is an inappropriate way of distributing already scarce resources. 'The reforms are potentially very wasteful. Many hospitals may try to develop new specialist units and will then find themselves competing for the same number of patients. Also, if a health authority finds that it is paying large amounts of money for a particular clinical service, it may decide to establish that facility itself. This would be wasteful financially and may even compromise patient care because it may take time to achieve a standard comparable to the original provider.

'We at the BMA believe that planning is essential. If you are short of money, as the health service undoubtedly is, co-ordination is the best method of allocation—the idea of competition will be disastrous.'

Despite the apparently overwhelming public and professional opposition to the NHS reforms, the Government has persisted with its legislation and in April fifty-six hospitals will become self-governing trusts. Dr Lee-Potter believes that they would face an uncertain future in a true market economy.

'The viability of the trusts depends almost entirely on how they are funded. By examining their business plans the BMA has determined that their combined requirements would constitute 15 per cent of the capital demands of the NHS, and yet they represent only 2 per cent of NHS units. Clearly then, their success depends on their receiving an extra slice of the cake and this would be to the detriment of other non-trust hospitals.

'In fact, the results from a Coopers and Lybrand report, commissioned by the Government, showed that only fourteen of the fifty-six hospitals were actually viable propositions. The BMA has conducted a similar study and using all the evidence available we found that a maximum of twelve trust hospitals were likely to survive.

'These predictions have caused great anxiety, but of course the Government will not allow any of the trusts to fail. Block contracts are being devised and

it is thought that the patterns of referral will be unchanged for the first year—so in effect the reforms won't really be happening. I believe that the Government does not want the full rigour of their ideas to be on display prior to a general election. They will not allow the health service to appear in a state of collapse in a year when they may seek re-election.

'I find it particularly disturbing that one hundred and twenty-one hospitals are set to become self-governing trusts in April 1992. For doctors, of course, the election is not a concern, but if the Government tries to bottle up the bad effects of its reforms until after an election, the consequences for the NHS could be disastrous. This is why I consider it very important that the BMA continues its efforts to persuade the Government at least to slow down and examine the results carefully before proceeding to the next stages.'

Dr Lee-Potter stresses that the BMA must not become embroiled in a political discussion. 'Some people appear to be taking the view that this Government is a lost cause as far as protecting the health service is concerned. But we must now be drawn into that sort of party political discussion.' In fact the BMA were very enthuastic when Mrs Thatcher first announced that there was to be a review of the NHS. They had high hopes that many of the problems faced by the NHS and the medical profession would be addressed, and looked forward to talks. But it became clear that it was ideas from managers, not doctors, that the Department of Health sought. Dr Lee-Potter feels that doctors are being undermined as managers are given more authority and influence; he considers this issue as important as the NHS reforms.

'There is a great difference between leadership and management. In the NHS the doctors should be the leaders and determine policy, while the managers should simply oil the wheels. However, this is not how managers view their rôles and indeed they have been given the power to make major decisions—unfortunately it is often unclear how much attention has been paid to medical views.'

In many hospitals a forum for discussion of policy does not exist. Guy's is an exception to this and has a management board, on which clinicians hold a very strong position. But as hospitals become self-governing trusts, managers will probably assume greater importance, and even Guy's doctors, says Dr Lee-Potter, may find that the clinicians are usurped by the power of the managers on the board of trustees.

The Government contends that managers are necessary because the NHS is inefficient. Dr Lee-Potter, not surprisingly, disagrees with this assertion and believes that doctors could run the service very well if they had access to more financial information.

'I think that the problems facing the NHS are to do with a lack of management information and not management *per se*. The NHS requires

greater provision of management information and does not need any more highly paid general managers. The BMA is fully in favour of improving the quality of health care and welcome initiatives such as medical audit, but we are concerned about the level of central funding for these exercises. For example, Marks and Spencer's emphasise quality but their goods cost a little more than other food stores as a result.'

One group of doctors within the NHS who are being given the opportunity to control their finances are general practitioners. They are now able to manage their own budgets and buy in the services their patients require from local health authorities or self-governing trust hospitals. The response from GP's to this offer has generally been unenthusiastic. Dr Lee-Potter thinks that GP's are 'wise to be wary' and may find that the reforms will in fact reduce their autonomy by allowing strict central control of their capital allowance.

However, Dr Lee-Potter welcomed the recent agreement to reduce the hours worked by junior doctors. He was keen to point out that the BMA had steadfastly supported the juniors throughout their campaign: 'Although some consultants feel that because they had it tough their successors should suffer too, that certainly was not the feeling here. We supported the doctors both politically and financially, and we're very pleased with the outcome of negotiations.'

Despite this, he is not sure, whether, as a schoolboy today, he would choose a career in medicine: 'I would have more doubts. When I entered medical school it was easy to see the way ahead. Now the prospects for the NHS and medicine are less certain. I think the status of doctors has diminished and the publicity about juniors' hours has made the job seem unattractive. Young people may now be drawn into careers offering more realistic remuneration; but the other rewards from medicine will always be great because it is such a worthwhile job.'

Dr Lee-Potter seems to thinks that the reforms will not improve patient care but will alter the relationships between doctors in the NHS. As hospitals become self-governing trusts they will find themselves having to compete with other units in the NHS; the alliance of doctors in support of the service will be broken as they are forced to defend their hospital against others; already some doctors are calling for budget-holding GP's to be disowned by the BMA; decisions will be made on the basis of short-term local considerations and tensions will be created within hospitals between those who oppose and those who welcome the reforms.

Dr Lee-Potter says he is an optimist. I would not want to hear a pessimist's view of the NHS.

TAP

The Shape of Things to come?

South London Press
submitted by Mavis Lowther

In Situ Hybridisation Analysis

The detection of chromosomal abnormalities

Since its foundation, the policy of the Paediatric Research Unit has been to combine scientific research with laboratory services. The success of this practice is highlighted, once again, by the introduction—in what is now the Division of Medical and Molecular Genetics—of the non-isotopic *in situ* hybridisation (ISH) technique as a tool to help colleagues of the Cytogenetics and Genetic Counselling sections in their investigations of patients with chromosomal abnormalities.

The principle of this new procedure is schematically illustrated in Figure 1. Cloned DNA probes, specific for different sequences on the human chromosomes, are first labelled by nick-translation with biotin. The single-stranded biotinylated probes are then hybridised to genomic DNA present in single cells (nuclei) or metaphase chromosomes, under conditions which would allow the stable formation of complexes. Briefly, for this purpose, the slides containing nuclei in interphase or metaphase spreads, previously treated with ribonuclease and proteinase K, are incubated overnight with the probe in appropriate buffers and at the optimal temperature. The slides are then subjected to post-hybridisation washes with buffers which will regulate the stringency of the hybridisation so that the probe will interact only with an identical sequence in the genomic DNA. The visualisation of the biotinylated probe is achieved by a further incubation of the slides in a solution containing fluorescein-conjugated avidin (avidin binds with very high affinity to biotin). Often, at this stage, the 'signal' is still weak but it can be amplified by adding to the slides biotinylated antibodies against avidin and then more fluorescein-labelled avidin. This creates a sort of multilayer macromolecular complex on top of the probe. The localisation of the probe is then investigated using conventional UV microscopy.

Many variations on this basic method have been introduced in recent years. The probes can be labelled with a variety of markers (e.g. acetylaminofluorene, digoxigenin or mercury dinitrophenol) and visualisation obtained using antibodies conjugated with either fluorochromes or enzymes, such as peroxidase or alkaline phosphatase (1–5).

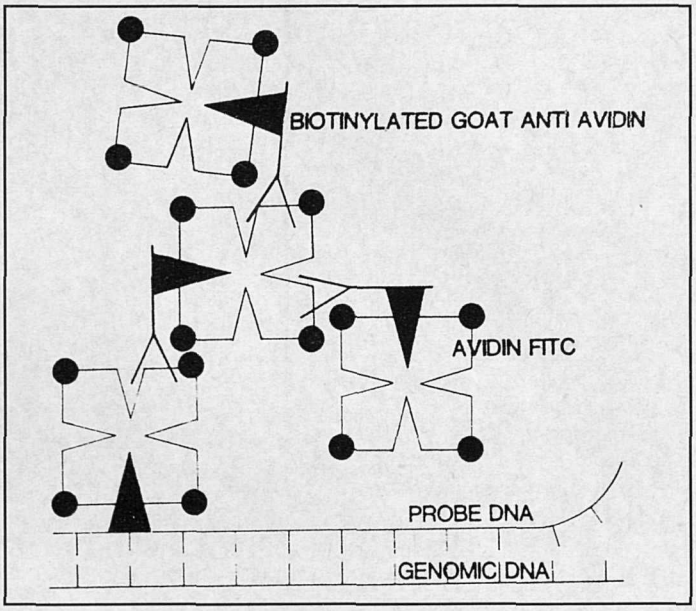


Figure 1: Scheme of the non-isotopic *in situ* hybridisation procedure. The probe is labelled by nick-translation with biotin (▲) and then hybridised with the genomic DNA in cells in interphase or metaphase. FITC-conjugated avidin ( ) is then added, followed by biotinylated antibodies against avidin ( ) and again FITC—labelled avidin. A further layer of antibodies and avidin can be used to amplify the signal. Variations of this approach include the use of other markers (eg acetylaminofluorene) and of antibodies conjugated with enzyme (eg peroxidase).

Examples of the application of the non-isotopic ISH procedure are shown in Figures 2–6, selected from the many cases investigated in our Unit (3, 6–9). Fig 2a shows the visualisation of the Y chromosome in lymphocytes in interphase obtained from a male subject; Y-derived repetitive probes, specific for regions of the short arm chromosome Y (Yp), were used for the detection of this chromosome. The bright fluorescent spots, marking the Y-specific probe, are absent in the nuclei of a female donor (Fig 2b).

Hybridisation of the Y probe on metaphase chromosomes is shown in Fig 3a, where the short arm of the Y chromosome is clearly visible. For comparison, Fig 3b shows a partial metaphase spread from a patient in whom the Y chromosome was translocated to an autosome (chromosome 13).

More interesting is the case of a young patient, phenotypically male, who,

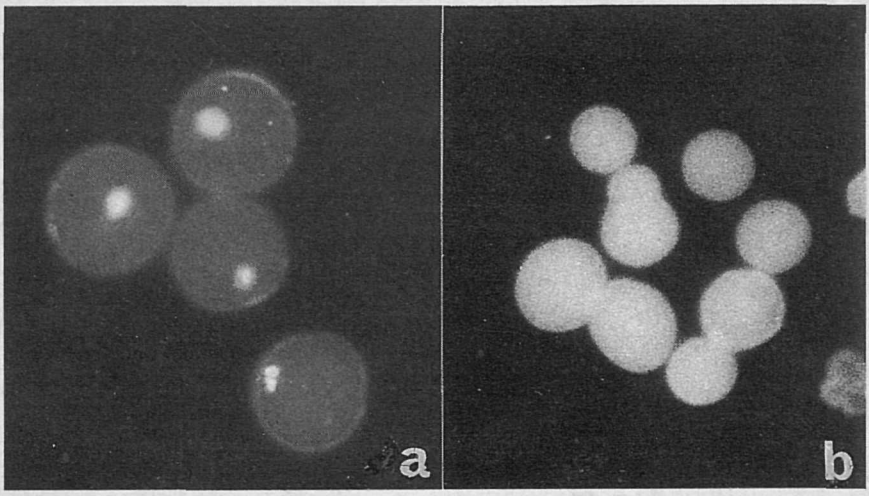


Figure 2: Fluorescent ISH of nuclei in interphase from a male (A) and a female (B) subject, tested using a Y-specific probe. A bright fluorescent spot can be seen in each cell from the male donor. Counterstaining with propidium idodide.

using conventional cytogenetic techniques, appeared to have a single X and no Y chromosome (45, X). Using Y probes and ISH, a small segment of the short arm of the Y chromosome, close to the region containing the testicular differentiation gene, was detected on the tip of the long arm of chromosome 10 (Fig 4) (6). This patient was further investigated using molecular genetics techniques and shown to have both an inversion and a deletion within the translocated Y segment (9).

Figures 5 and 6 illustrate the application of the non-isotopic ISH method to determine the origin of small chromosomal fragments. In these, as in other patients investigated in our Unit, the analysis of chromosomes in metaphase, performed using conventional staining methods, revealed the presence, in some cells, of fragments whose origin could not be readily established.

Using the ISH technique, and probes specific for the X and Y chromosomes and selected autosomes (13, 18, 21), it is often possible to ascertain the origin of the fragments. Fig 5 shows, for example, the detection of a small 'marker' of the Y chromosome which appears to have the structure of a 'ring'. The presence of a Y-derived sequence in this patient was confirmed using the polymerase chain reaction (PCR) and Y-specific primers. Another patient had a normal single X and, in some cells, from 1 to 3 'markers'. No staining was observed using a Y probe and ISH. However, when an X-centromeric probe

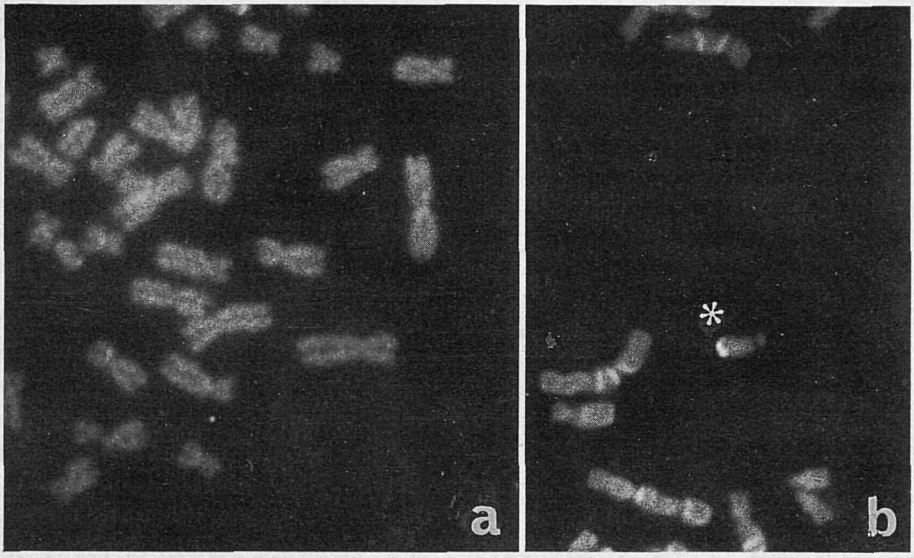
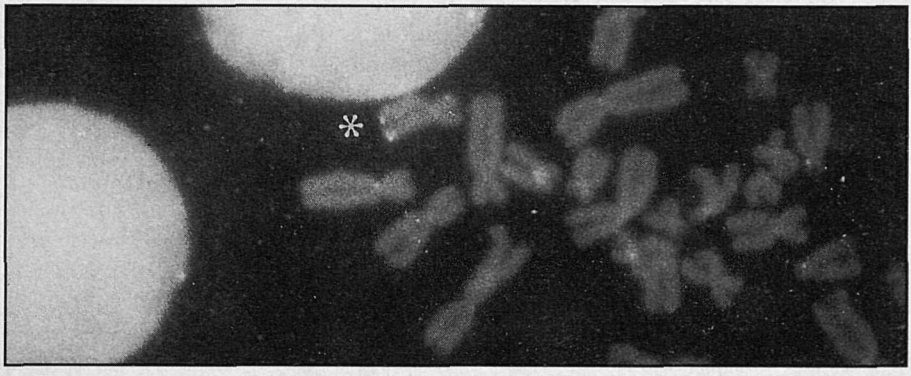


Figure 3: Chromosomes in metaphase tested by ISH using a Y probe. A bright fluorescent spot can be seen on the tip of the short arm of the Y chromosome in a metaphase spread from a normal male donor (a); this segment of the Y chromosome is translocated (*) to an autosome in another subject (b).

Figure 4: This patient, phenotypically male, appeared to have a single normal X and no Y chromosome when examined using conventional cytogenetics techniques. When metaphase spreads were analysed using ISH and a Y probe, a small segment of the short arm of the Y chromosome was detected on chromosome 10 (*)



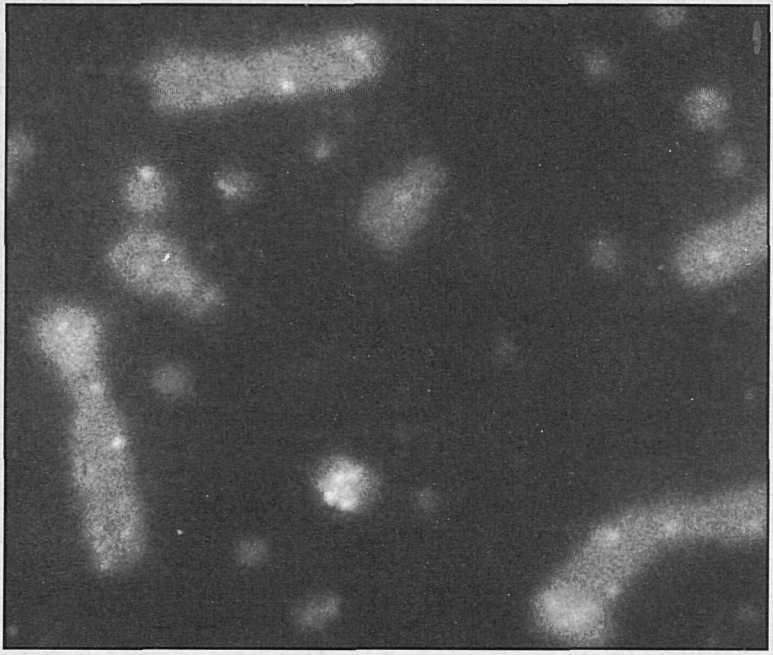


Figure 5: A chromosome fragment detected by conventional cytogenetic techniques could be identified as a Y ring, when analysed using ISH and a Y probe (partial metaphase spread shown).

was employed, the metaphase spreads were found to contain a normal X and from 1 to 3 X chromosome-derived fragments (Fig 6).

The identification of these X or Y chromosomal markers is particularly important from a diagnostic and prognostic point of view, since female patients with residual DNA materials are at risk of developing gonadoblastoma.

In our Unit, the non-isotopic ISH procedure, with its variants, has been used to investigate patients with abnormalities of the X, Y, 13, 18 and 21 chromosomes. It has also been employed to detect residual human chromosomes in mouse X man cell hybridomas.

It is a technique which offers many advantages when compared to the radioactive ISH method, particularly since it can be completed in a short period of time and has a very good spatial resolution. It can be applied to the analysis of any type of cell, including lymphocytes, fibroblasts, amniotic and chorionic cellular elements. It has been successfully used to investigate

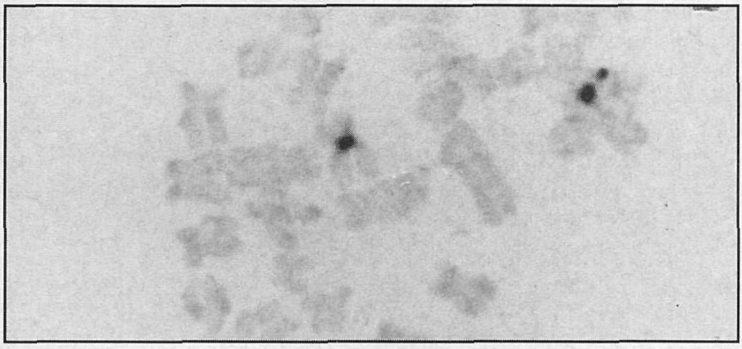


Figure 6: In this patient, using ISH and an X-centromeric probe it was possible to recognise a normal X chromosome and 2 fragments containing X-derived DNA. The metaphase did not stain when a Y probe was used. This patient showed a remarkable mosaicism, since some cells contained only the X chromosome, while others also contained 1, 2 or 3 X-derived markers (staining by ISH using peroxidase-conjugated antibodies).

chromosomal abnormalities and gene amplification in cancer cells (10, 11) and to map several genes on the same chromosome (12).

With the financial support of the Guy's Special Trustees and Action Research, work is now in progress in our Division to assess the diagnostic value of the non-isotopic ISH procedure for the detection of major chromosomal abnormalities in fetal cells in interphase.

Professor M Adinolfi
Division of Medical & Molecular Genetics
UMDS (Guy's Campus)

Acknowledgement: The work described in this note is the result of close collaboration between members of the Cytogenetics, Genetic Counselling and Immunology sections of the Division.

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Gas! Gas! Gas!

A Gulf Anaesthetist's Story

On 6 August 1990. I started my second year HPT as Honorary Senior Registrar in the Department of Anaesthesia at Guy's. It was an eagerly awaited return to Guy's as I had trained there from 1972–1978. Since then I had done RMO jobs and trained as a GP, before switching over to anaesthesia in late 1984.

My return to Guy's was a short one. One afternoon, during a neurosurgical list Professor Adams passed on a message to me. I was to ring a London number as soon as possible. There followed a whirl wind of activity and by 22 August I found myself reporting for duty as anaesthetist to an MST at 16 Fd Ambulance in Bulford. All I knew was that this was part of the medical response to the military operation codenamed 'Operation Granby' for the Gulf region; as on the 2 August Iraq had annexed Kuwait as its nineteenth region. But what was an MST? Much later we discovered that it stood for 'Medical Support Team'; which in essence was a beefed up FST or 'Field Surgical Team'. We were MST Bravo. MST Alpha had already been deployed to Dharan. These are the only MST's deployed in the Gulf.

The MST consists of a surgeon, anaesthetist, two ODA's, a scrub nurse, a dentist, a dental assistant, four nurses, medics, drivers and a command and clerical element. A total of 35 men; well we did have females, but they were transferred to other medical units before our deployment. MST Bravo is essentially an Army unit, but with an RAF contingent and a single Marine medic, we are proud to be a truely Triservice set up (albeit all male).

Preparatory phase

The first few weeks were used to obtain our equipment from mobilization stores. Every item that could possibly be needed, either to live in the field or provide a surgical service, had to be obtained, packed and weighed (as there were flying restrictions with respect to weight and types of cargo).

Simultaneously, personal documentation (passport, identity cards, dogtags, etc) had to be obtained and medical checks (innoculations, dental checks) performed; personal war kit also issued (especially individual protection equipment or 'IPE').

We started training in fieldcraft, which included fitness training, NBC drills, weapon handling, erection of tentage and 'colpro' (ie NBC collective protection, which allows work and rest in protection against the chemical threat without the need of IPE).

We used this time to prepare protocols on aspects such as resuscitation (we adopted the ATLS regime completely), ivi fluid therapy, antibiotic policy and NBC treatment regimes. All our preparations were tested individually and finally collectively in a deployment to the Army Medical Services Training Camp at Seighton, Cheshire. Medical plans are dependant on operational plans; so there was an inevitable frustrating delay in our move to the Gulf.

Deployment Phase

We finally left for the Gulf on 20 October 1990, in an airlift by four Hercules C130 aircraft from Lyneham, via Akrotiri, to our final destination, an airbase in NW Saudi Arabia. We were sent here to provide surgical cover for an RAF squadron. The base was also used by the RSAF and the USAF; but each nation provided its own medical back-up.

The site for our MST was selected by the local military authorities; and in slow time (because of the heat) we erected the tentage and colpro. Within 72 hours of our arrival we were able to provide a surgical service. This was greatly appreciated as a few days previously an aircraft had crash landed, and both crew members had sustained severe injuries.

The problems we face have been varied; and have included temperature extremes from 43°C to −5°C. This makes working conditions trying, to say the least. Other difficulties have included the fine dust that seems to cover every thing; availabilty of drinking water; water for ablutions; toilet and washing facilities; communications; documentation; providing air raid shelters; and security. Each task has been solved by a combination of persuasion, coercion and sheer determination. Heat related illnesses were not a problem thanks to a sensible work schedule, enforced water breaks, and a close surveillance of each other. We also designed a cooling bed. This was based on data provided by Professor Seraj at Riyadh who has investigated heat stroke cases at the annual pilgrimage to Mecca. We have so far had one case of pyrexia that was treated in this manner. He was a toxic case of acute appendicitis, and after the operation he was cooled by placing him on a hessian bed frame, covering his naked body with a bedsheet, and spraying him with a fine mist of warm water and blowing hot air from an electric fan heater over him. Within 30 minutes we managed to cool him down from 40°C to 38°C and he then remained apyrexial (helped too of course by the appendicectomy and antibiotic therapy). A similar method had been used in ITU on five cases of heat stroke in the UK with similar success!

We had 'acquired' several litres of ivi fluids and in addition we have 50 units of blood available at any one time. Supplies are reasonably quick, but only careful stock checking has helped to keep our us at an operational level.

The anaesthetic equipment is still primarily based on the TSA or Triservice Apparatus, but we also have the luxury of a Cape TC 50 ventilator, monitoring equipment that includes a Dinamap, a pulse oximeter and a peripheral nerve stimulator; and a syringe pump that is used for providing a TIVA (total intravenous anaesthesia). Oxygen is in limited supply, but now that we have taken delivery of oxygen concentrators this is no longer a problem.

We have a limited holding capacity, and the plan is that all P1 and P2 casualties would be casevaced to a general hospital either in theatre, Cyprus or the UK, depending on prevailing circumstances.

We have supplemented the field documentation with an extra anaesthetic form so that staff in the next echelon would have as comprehensive account of clinical details and therapeutic intervention as possible.

Survive to operate (STO)

In the run towards the UN deadline on the 15 January 1991, we were busy with improving the setup. Individual skills were enhanced by a series of clinical lectures. The GP's and dentist have been very busy, but fortunately I have had to give only four GA's so far; but at least it has given us confidence that the setup works, and after each case we have taken steps to rectify any problems. The Yanks have just received their ATH (Air Transportable Hospital) with four surgical teams and full back-up staff. This has taken away the clinical isolation we had experienced. I am pleased to report that the TSA continues to fascinate the American anaesthetists, who are dumbfounded at its simplicity and its versatility! Incidentally, the ATH has come out with all the equipment it would use in peacetime. We meet regularly, and are able to 'swap' bits of kit, drugs and expertise. It is very satisfying for me to talk to fellow anaesthetists and the CRNA's (Certified Registered Nurse Anaesthetists). Only 40 per cent of anaesthetics are given by doctors in the USAF, the bulk is done by the CRNA's. The USAF had used dentists as anaesthetic assistants, but decided that it was not so effective professionally or financially. Our contacts with the Saudi medical authorities have proved to be useful. We were particularly pleased to have access to the medical library at the local military hospital. However the medicolegal situation does not permit us direct clinical practice. The library provides me a useful bolt hole, where I can read various books and journals. To date, all correspondence to the medical journals have suffered from the delay in receiving and sending mail. We are hungry for information, and although we receive newspapers a few days late, I particularly follow the medical coverage. I noted that Dr Bihari (Director of ITU at Guy's) made

some comments on ITU facilities in the NHS for servicemen injured in the Gulf; and the BMJ leader of the 19 January 1991 by Dr Volans (Director of the Poisons Unit) was on the chemical threat. I am very fortunate that both civilian and military colleagues have kept in touch; and these correspondences are an important morale booster. I am fortunate too that Sarah Whiting the librarian at our HQ, does a grand job in sending me textbooks, reprints and literature searches, so I do not feel entirely deprived. I am very grateful to all those people who have kept in touch.

Christmas was very subdued and was essentially a private affair. However, the MST's Boxing Day barbeque was rudely interrupted by a SCUD launch! The food was burnt, but after the 'all clear' we managed to see the funny side of things. Over Christmas we were flooded with cards and greetings from wellwishers in the UK. The MST has adopted a few of them; and this has resulted in a healthy exchange of correspondence and parcels. It looks as though there will be a number of parties held for us on our return to the UK.

The New Year was greeted with heavy rains. The rain water just floats on the surface of the desert and this meant that we had to take down the whole setup. We redeployed to a drier patch of ground and had the original site tarmaced (with a slight slope to drain all the water away). We moved back to the improved site just 24 hours before the deadline. It was a hard slog but the team spirit carried us through.

Operation Desert Storm

The UN deadline passed and eventually at 0600 on 17 January 1991, active service was declared. After the initial euphoria, life has settled down to a routine in keeping with the ever present threat. Every time Iraq releases a missile at Israel, we have to seek cover as the initial trajectory could mean that the missile is heading our way. This has resulted in several 'Red Alerts' and we carry our respirator and webbing all the time. Every time the base has a mission, we count the boys out and count them back in; if all get back there is a great sense of relief. We have a great admiration for the aircrew, and we are all proud to be serving them. Obviously I cannot give details of our workload, but suffice to say it has not been too taxing. My highlight so far, has been a helicopter mission to pick up the aircrew of a Tornado, who had ejected due to control malfunction. It was a true multinational effort. The first Saudi chopper took an American Flight Surgeon to locate them, and a second Saudi helicopter took me and two medics. Fortunately both aircrew were only slightly hurt, and were transferred by the first chopper to the triage area. Here they were checked by a Pakistani Flight Surgeon and, of course, our own surgeon. It was an exhilarating experience to savour once it was all over, but was not helped by the fact that there was a 'Red Alert' just as we

took off. The incident was widely covered by the press and I believe that it also made the 6 o'clock news. I expect the saturation media coverage has brought the Gulf news to everbody's living room, so there is nothing more I can add. Like every body else, I just want to get home to my wife, family and friends; have a good break, charge up my batteries and continue my anaesthetic training programme. I would like to take this opportunity to thank everybody at Guy's, especially Professor Adams and Dr Dobb of the Anaesthetic Department. Best wishes to all the readers of Guy's Hospital Gazette. Keep writing!

Major W F de Mello, RAMC
Medical Support Team Bravo,
Operation Granby,
BFPO 639.

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

Seventy Years On

The reminiscences of E D Y Grasby

I reported to the Dean, Professor T B Johnson on 6 October, 1921. I was seventeen years old.

One of the first students that I met was Scott-Russell Trick, who was to become a splendid and life-long friend. Neither of us had studied biology at school and we were quickly introduced to Professor T J Evans. He was a delightful Welshman and a splendid teacher, with an astonishing knowledge of Ur and the Chaldees. We were utterly bored, however with biology and dissecting frogs or, worse, dogfish was purgatory. My eyes have always been troublesome and the aldehyde in which the wretched fish were preserved produced such lachrymation that I could not see the fish, let alone the nerve collar—or was that the lumbricus?—that we were supposed to identify and dissect. We were both glad when we passed the examination.

The dissecting room (on the present site of Nuffield House) appalled me. I had nightmares, dreaming of dissected bodies with exposed rib cages and heaving lungs. The senior demonstrators were Grant Massie and George Doherty. Doherty had recently married and on one memorable occasion he unintentionally reduced the class to howls of laughter. He was describing, with the aid of drawings, the penile urethra and said that adding the various parts together gave a total length of four and one half inches. He then looked at his drawing and said: 'I can't make mine four and a half inches long'.

Both Trick and I qualified conjoint at the age of twenty two, and at last began what we considered to be real medicine. In accordance with MB regulations we began with three months of genito-urinary surgery and orthopaedics; we were appointed to 'Rudie' Thompson's firm for the former and to W H Trethowan's firm for orthopaedics. I remember Treth with great affection. He was a musician of talent and had a cathedral size organ built in the basement of his house—much to the annoyance of his neighbours.

Later Trick, F J Sale, S E Theis, E J Pye-Smith, Ronald Jarman and I were appointed Clinicals. The physicians in Clinical were A P Beddard and Herbert French, and we spent six weeks with each of them. It was a very valuable and instructive appointment as we had the pick of all cases admitted to Guy's.

It was customary for the Clinicals to entertain the physicians in the Clinicals' Room in Hunt's House. We decided on pheasants but Jarman, who bought

Above: Guy's operating theatres, 1925.

them, insisted that they be hung for a week prior to the dinner. Unhappily they were hung over a radiator and although we frequently complained that the smell suggested that they were a bit ripe, Jarman maintained that they were fine. On the day of the dinner they were taken to Cook who was horrified at the pultaceous mass and threw the birds into the dustbin. Ronald and I leaped into a taxi and bought two ready-cooked birds from Fortnum and Mason—they cost a fortune.

Five of the Clinicals were appointed Assistant House Surgeons, and I became AHS to E G Slesinger. 'Slecky', as he was affectionately known, had a distinguished First World War record and had been awarded the Croix de Guerre, avec Palme, but I never discovered why he had been awarded this double distinction. However I do know that he was once wounded and when he recovered consciousness he found another casualty lying next to him with intestines protruding from a rent in his abdominal wall. Using safety pins from his field dressing, Slecky managed to pin his comrade's wound together before becoming unconscious again. Slecky awoke in a hospital ship to find that same man in the bed next to him. Both survived.

I enjoyed my months with Slecky. He was kind, considerate and an excellent surgeon. However, at that time he was carrying out partial thyroidectomy for

exophthalmic goitre on overstimulated and excitable patients. These people were not the best subjects for surgery and we had some anxious sessions. For drainage of the wound he used an angled glass tube with flanges at each end. These were inserted through the incision using forceps and inevitably some broke. I would often be called to blame and we were then left with the unenviable task of finding all the fragments of glass before inserting another.

It was also my duty, before the operation, to ask the woman—they all seemed to be women—to wear a favourite necklace. I then drew a line underneath it with silver nitrate to mark out the line for the incision in the hope that after the operation the jewellery would hide the scar. It was a nice thought.

Later I was lucky enough to be one of the four AHS's to be appointed Out-Patient Officers. It was a non-resident job and we were paid three pounds a week. It combined one day as Casualty Officer in the Front Surgery and the next day acting as Out-Patient Officer to see mostly chronic patients.

It was almost a light relief after being an AHS and I even managed to play a little golf. I remember being asked by Dr Conybeare, the Warden of the College, to make up a four with Sir William Morris, later Lord Nuffield, the great benefactor of Guy's. We were to play at Huntercombe Golf Course, near Oxford, a club which I believe Lord Nuffield bought outright after being refused membership! Conybeare had a remarkable boat-shaped Buick, with a wooden deck over the back seats. There was no hood. Off we went on a bitterly cold day and duly arrived at the club absolutely frozen. The match was cancelled because of rain and so we arrived back at Guy's both cold and wet.

Working in the out-patients' department certainly had its moments. One old boy suffering from arthritis of the knees said: 'That last drop of medicine fair touched my stomach up, Doctor'. He had been given Lin Sap, a preparation containing soap, camphor and industrial spirit. This was meant to be applied externally, but instead he had been taking one spoonful three times a day—not suprisingly he also complained of some laxity of the bowels.

Duty in Front Surgery also produced some surprises. A father brought his small son aged about four, to Casualty complaining that the boy had the arm of his Teddy bear stuck in his finger. It looked fantastically ridiculous. The furry arm *was* stuck in his finger, poking out as if it was growing there. However, I thought I could feel something at the base of the finger and what had happened was that the boy had tried to stick the arm back on his Teddy, his fingers slipped and he stuck the point in and the metal wire had wound itself subcutaneously round the base of the finger. By simply unwinding it, the wire came sweetly out. The boy never made a sound. There was no

bleeding and away he went clutching the arm in his hand.

On another occasion a thirty year old Billingsgate porter came into Casualty. He was a big chap and wore the traditional heavy round leather hat, reinforced and strengthed at the top. 'It's me elbow, Doctor. I got a lump there,' he said. There was was indeed a callosity, with a round hole in the centre, from which protruded the head of screw. Sister and I closely examined it, but neither of us could really believe what we were seeing. The man denied any knowledge of it, so I simply unscrewed it. It was an old rusty one and a half inch screw. Eventually it transpired that at the age of ten he had fallen and injured his elbow (he in fact fractured the olecranon process) and Sir William Arbuthnot Lane had inserted the screw during an operation at Guy's.

Arbuthnot Lane was an early proponent of orthopaedic surgery, at least a host of surgical instruments, including metal plates and bone forceps, were manufactured by Down Brothers and bore his name. The screws were obtained from the Carpenter's Shop at Guy's, put into pure Lystol to sterilise them, and then used forthwith. He was a superb surgeon but was hopelessly autocratic and full of fads. He was a devotée of the healthy life—plenty of fresh air and so on—and decided, most unwisely, that the colon was, as he put it: 'The cesspit of the human body' and he promptly removed it from unsuspecting patients. He was so good a surgeon that his patients recovered from these massive assaults—massive operations in those days—but even when I was a House Surgeon there were still a few of his patients attending for treatment of their intractable diarrhoea.

I met Arbuthnot Lane when he was an old man and conversation was difficult as he had become stone deaf. He was an imperious man even then. He expected the traffic to stop whenever he crossed the road and would never think of looking round. Eventually he was knocked down by a car.

He was a great man, misguided in some views and not strictly honest about others. Fresh air? Not at all. I was told that he had all the windows in his house screwed closed.

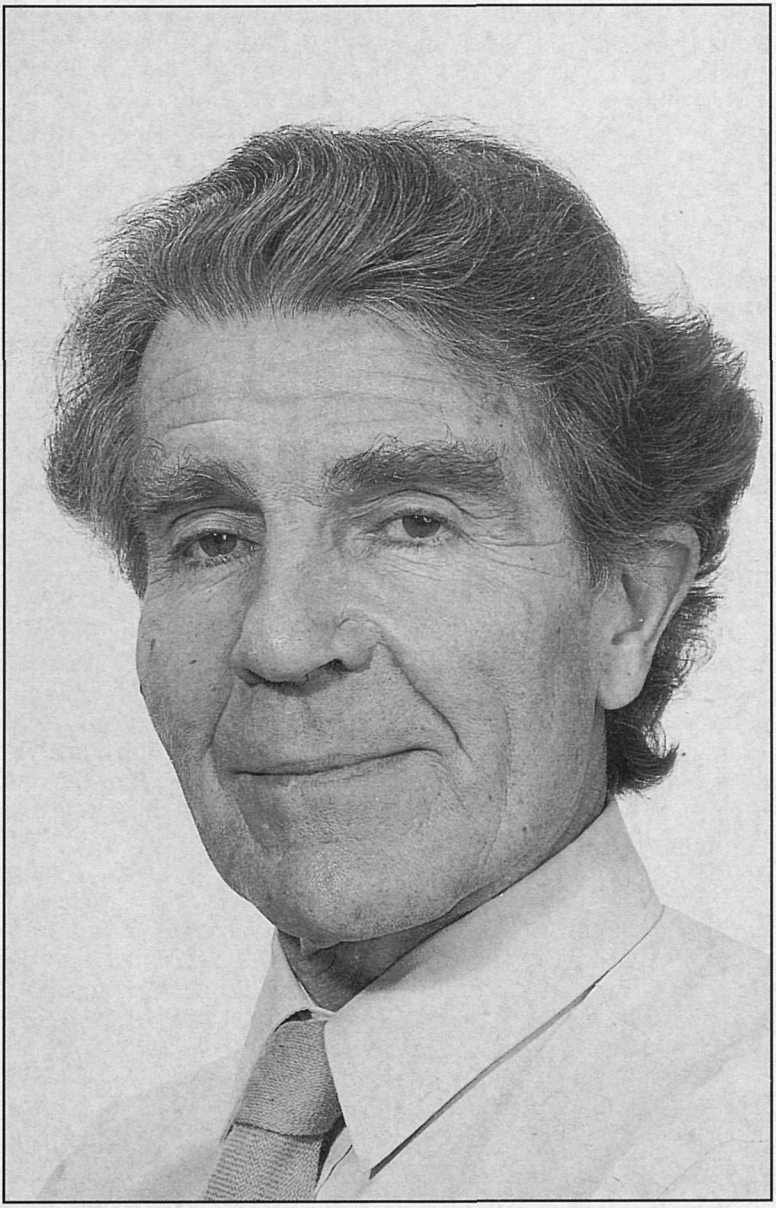
Professor Cedric Mims

An appreciation of the roving microbiologist

Cedric Mims BSc, MD, FRCPath, retired from the University chair of Microbiology at UMDS (Guy's campus) in September 1990. He was appointed in 1972 and served the United Schools with great distinction. It needs to be said from the outset that he was by no means a classical professor of microbiology. Cedric's training was in virology but he was equally conversant with immunology. His depth of knowledge of infectious diseases as they affect the patient or the animal was truly astounding. The textbook he first published in 1977 entitled '*The Pathogenesis of Infectious Disease*' presents a unique understanding of microbial diseases and established itself as a classic. It is compulsory reading for students and specialists alike.

Cedric Mims was born in 1924 and was educated at Mill Hill School. His first university degree was a BSc in Zoology (first class honours) at University College, London, in 1947. He then joined, as a demonstrator, the medical physiology department, led by the celebrated Professor Samson Wright, at the Middlesex Hospital Medical School. He qualified MB BS at the Middlesex in 1952 and after his pre-registration appointments he embarked on a long and distinguished career abroad. His first appointment, as the medical research officer at the Virus Research Institute at Entebbe, Uganda, may well have rekindled his interest in animal pathogenesis which had begun during his BSc course in Zoology.

In 1956 Cedric Mims moved from Uganda to Australia to join the department of microbiology at the John Curtin School of Medical Research, Canberra. There he worked under Frank Fenner, who was one of the world's leading authorities on viral pathogenesis. A great deal of his research on the mechanisms of persistence of viral infections, the role of macrophages and the pathogenesis of lymphocytic choriomeningitis viruses was carried out in Canberra over a period of sixteen years. It must be appreciated that at that time Australia was the epicentre of immunology, with Sir MacFarlane Burnet's revolutionary theories in immunology. In 1968 Cedric's contribution to medical science was formally recognised by his being awarded the Professorial Fellowship of the University. Cedric was also awarded the Rockefeller Foundation Travelling Medical Fellowship in 1963–64 and he was wise to spend that at the renowned William Dunn School of Pathology, under the influence



of Professor J L Gowans who was at that time pioneering research on the circulation of lymphocytes. He then moved to the Division of Infectious Disease Research, at the Children's Hospital Medical Center in Boston. The head of this unit was Dr J F Enders, who won the Nobel prize for his work that led to the discovery of the poliomyelitis and measles vaccines.

Before Professor Mims was appointed to the chair at Guy's, he was an established authority on the pathogenesis of viral infections. He joined Guy's in 1972 and soon established himself among students and colleagues as one of the most popular personalities. Cedric's knowledge of microbial diseases was astonishing. He kept us equally spellbound at luncheons in the Medical School with his detailed knowledge of the sexual habits of the animal kingdom, ranging from the humble fruit fly to the rhinoceros, with hilarious qualitative and quantitative data.

Professor Mims had a profound influence on the teaching of microbiology at the School and there was a quantum leap in microbiological research after his appointment. In particular he made fundamental contributions to the knowledge of the virulence and cellular immunity to cytomegalovirus, virus-related immunomodulation, and the role of interferon in certain viral infections. During Cedric's term of office at Guy's, and later the UMDS, he was awarded Visiting Professorships to the Johns Hopkins University, Baltimore and the University of Western Australia in Perth. His expertise was greatly in demand outside the School and he served on a number of Medical Research Council Committees, the governing body of the Animal Virus Research Institute in Pirbright and on the Scientific Advisory Committee of the Multiple Sclerosis Society. For many years he was on the Tropical Medicine Board of the MRC and during this time made numerous visits to countries in sub-Saharan Africa. His critical but fair scientific appraisal of virology led to him becoming an editor of the *Journal of General Virology* and to appointments on the editorial boards of four other international journals of microbilogy.

The retirement of Professor Cedric Mims has created a hiatus which will be well nigh impossible to fill. However, as is often the rule with active minds who are obliged to retire because of an arbitrary convention of the University, Cedric has embarked on a new challenge: he is investigating death. He now spends a great deal of time in the library of the Royal Society of Medicine, with the objective of writing a book on the disposal of the dead. It is perhaps not an accident that sex and death, the two principal biological forces, should have evoked such a profound interest in Professor Cedric Mims. I have little doubt that the project he has initiated will be crowned with success, particularly in removing the taboo of death from society and highlighting the dual responsibility of doctors in the life and death of their patients.

TL

Ratty Checks on The Flora And Fauna

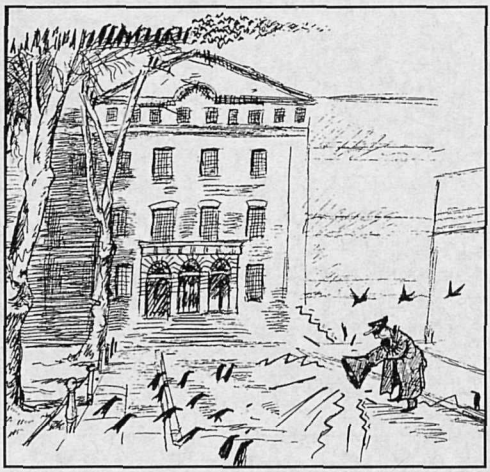
As winter approached, Ratty decided to put on his fur coat and have a look around Guy's. During the excavations around the base of the Tower, Great Maze Pond had been rather too busy for his taste and he had kept away from it. He decided that he would like to see how the plane tree was getting on (The Parable of the Plane Tree, *Gazette* 1984). Turning the corner at the Friends shop imagine his surprise when he could not see the plane tree and, when he scuttled over to take a closer look, he was horrified to find only a hole in the ground where the tree had once stood. Of course it had never really recovered from the assault on it seven years ago. Each spring a few slender shoots with some leaves on them had appeared but these had never looked as though they would grow once again into a great tree. Whoever had attacked it had caused mortal wounds but Ratty felt sad that the tree had disappeared without a trace and with no protest.

Above: Ratty finds the plane tree has gone

Turning back to the Park, Ratty decided he would watch a phenomenon which had intrigued him since last year. For a long time the tall plane trees in the Park had provided roosts for thousands of starlings. The numbers seemed to be increasing and the mess they produced below on the cars, the pavements and often the passers-by had become a serious problem. The authorities had shown great imagination in tackling this and had employed the services of an expert. He experimented with the noises of a sparrowhawk and of frightened starlings, played just before dusk. It was found that when starlings heard sounds of their terrified brethren they flew away. During the autumn of 1989 a member of the hospital staff stationed himself in the Park and played these sounds each evening which caused the approaching birds to change their minds and turn swiftly towards the more peaceful, and apparently safer, St James's Park.

The same procedure was undertaken in the autumn of 1990. At first it seemed to work but the starlings came to realise that there was no danger in approaching Guy's even though the volume of noise from below was turned up. Each evening the Bird Officer would come to the Park with a larger and louder instrument until the noise from the machine consisted of deafening shrieks (clearly audible to all the patients in the hospital but apparently ignored by the starlings who would line up to listen.) Perhaps they thought it was some kind of pop festival. Ratty watched this performance several times but eventually he had to keep away because the noise was damaging his ears.

Below: Scaring the birds.



Essentials of Dermatology Third Edition, J L Burton Churchill Livingston, 299pp, Priced £10.95.

With the current erosion of dermatology from the medical student curriculum, a good dermatology text is an increasingly important part of the well informed medical students' bookcase. Dr Burton's book is a handy sized paperback, sensibly priced at £10.95.

The book starts with a chapter on principles of diagnosis and then looks at disorders classified according to the principal sub-organ of the skin involved, following which diseases of infectious aetiology, photodermatoses and so on are discussed, with separate chapters on eczema and other topics which do not fit comfortably into the preceeding chapters. Each chapter is well organised, readable in a short session and is preceded by a discussion of the normal anatomy and physiology of the skin relevant to the topic being discussed. This an elegant and easily assimilated way of understanding the basic scence which is deranged in the many diseases of the skin.

What of the book's content? I thought that the subject was generally very satisfactorily covered. Clearly in any one person's account of diseases of the skin there will be variations in emphasis, and it would perhaps have been nice to have read more about diseases such as epidermolysis bullosa, which although rare cause such agony to some patients. Also, the chapter on immunodermatology is rather brief, considering the large number of dermatologists who devote their lives to this topic! The book is well illustrated, with both half-tone and colour plates, in addition to many line drawings. These are generally well chosen and the black and white plates are a useful reminder that colour reproduction is not a *sine-qua-non* in the conveying of dermatologic information.

Dr Burton's style of writing throughout is very easy to read, in places hilarious. There are many interesting asides: I was unaware of the derivation of the word 'puce' until I read the chapter on dermatoses due to parasites.

In summary, I think this is a valuable book which I would certainly have on my short list of texts when choosing an undergraduate dermatology manual.

R Groves

Depictions Of An Odyssey By Peter Mackarell, Edited by Sheila Paine Published by Nsead, Corsham, Wilts.

On the corridor walls of a top floor in Guy's are displayed a series of small gouache paintings. Visitors and hospital personnel are regularly captivated by the colourful works which painfully illustrate the impact of optic neuritis on an artist's perception of light and form. This book is a posthumous and touching tribute to the painter and patient, Peter MacKarell.

It was in 1980 that he experienced the onset of multiple sclerosis to which he succumbed eight year later. The artist's struggle with his illness, his fortitude and persistently enquiring nature are described in various ways by himself and three commentators. It is a slim volume which is well written and the text is illuminated by reproductions of Peter MacKarell's illustrations and paintings.

The foreword is by Richard Hoggart who was warden of Goldsmith's College where the artist was a teacher. It is a warm and generous introduction which alludes to the artist's 'incarceration' in various

hospitals each of which inspired distinctive moods affecting the artist's creativity. Gloom and despair characterised a period in a ward for the young, chronically disabled. The first chapter is by Bevis Hillier, who is a writer. It provides some information about the artist's career as an illustrator and cartoonist. A second chapter is by a fellow painter Stanislav Frenkiel who movingly describes the changing styles, techniques and subjects of the painter as his circumstances and vision alter with the illness.

The last two chapters are by the artist himself. He writes about the optic neuritis which declared the onset of his disease. The penultimate chapter thus describes worsening of vision, blindness and recovery in puzzled detail. The series of highly personal pictures which illustrate this experience and which are so familiar to many at Guy's are reproduced here. A later sequence of pictures painted during convalescence now hang in the Institute of Ophthalmology. The last chapter contains some excerpts from an illustrated journal he maintained for his daughter while in a nursing home. His decline is apparent. In the closing pages he struggles to make sense of the confused images of shape and colour, analysing them with an artist's training, reflecting fondly on earlier painters who had influenced him and philosophically engaging his illness without self-pity.

It is the pictures which speak most effectively for the artist. Water colour landscapes of Irish coastline and multiple ink illustrations indicate that he was supremely talented. The pictures and drawings performed during his illness reveal something else, namely a courage and professionalism which must have inspired those family and carers who were close to him.

T Gibson

PHYSIOTHERAPY NOTES

Ann Hunter

Ann Hunter has been appointed to the new post of Director of Therapy Services within the Self-Governing Trust. She will manage the Occupational and Physiotherapy service across the Trust and be responsible for professional guidance and advice for the physiotherapists across the Community Health Services. By the time this piece comes into print she will have been in post from 25 February.

The Trust-Wide Directorate is the new look for the 90's and much innovation and delicate management will need to take place to achieve the integration of these two therapy professions which presently work side by side in the rehabilitation of our patients to as independent a life as possible.

Ann is Scottish by Nationality and a physiotherapist by profession. Having trained at the Glasgow Royal Infirmary she gained her general basic experience in England, Canada, Spain and Scotland.

Her particular clinical interest and expertise is in the treatment of people who have been brain damaged and she was involved in developing these skills at senior level in Australia and the UK, working also in Mental Health and Services for People with Learning Difficulties (SPWLD) Higher qualifications include an MA in Manpower, a DMS (Health) and a certificate of health economics from the University of Aberdeen. Recent work has been involvement in compiling a National Charter on Standards for Physiotherapy Practice. This work was launched by the Chartered Society of Physiotherapy (CSP) in the Autumn. We are hoping that we will be helped to move forward more quickly in our own small steps of standard setting, when one of the pilot team heads up our services. Not only does she sit on various committees and working parties but also she is a member of the Health Advisory Service Teams which review Elderly Services and Mental Health Services.

With all this energy spent on professional activities one would expect this Scottish therapist to collapse, out of working hours, into a large armchair to recover. Her recovery process, however, seems not to be one of rest but of even greater physical activity. Tennis, golf and jogging take up much of her relaxation time, but it cheers me to learn that she does stop sometimes when she enjoys listening to music, visiting the theatre or settling into a good book.

Talking of books, Ann has written the chapter on quality assurance in a new book '*Management in Physiotherapy*' which is edited by Bob Jones, who was on the staff in Guy's from 1973 to 1976. It is the first book of its kind and is, in the greater part, by physiotherapists for physiotherapists. It is full of useful information and is very readable. It is interesting to note that three out of five of the other physiotherapist contributors have been on the staff at Guy's. I find it very gratifying that so many prominent physiotherapists have passed through the portals of Guy's and I hope that our tradition will continue through into the new era.

Diana Innocenti

Forensic Dentistry

The Dental Society lecture programme started its 1991 season on 10 January with a record attendance of approximately 140 people. The lecture was titled 'Forensic Dentistry' and the speaker was an old Dental Society favourite, Dr Bernard Sims. Many had heard him speak before, but were keen to hear him again. They had also passed the word around that his lectures were always fascinating, often a little gory (and perhaps not for the faint hearted), but one not to be missed; which helped to promote the excellent turnout. Those who had never been to a Dr Sims' lecture before, sat completely mesmerised by the many amazing slides he showed to illustrate his lecture, and were often

heard to make noises of disbelief at some of the more grisly slides.

The whole area of forensic odontology is fascinating, especially to the dentist. The teeth, we were told are often the only part of a body to survive after some forms of disaster, such as fires and prolonged immersion in water, especially sea water. The most recent mass disasters in which the work of the forensic odontologist were of prime importance are: the King's Cross fire, The Lockerbie, Manchester and M1 plane crashes, and the sinking of *The Marchioness* and *Herald of Free Enterprise*. The forensic odontologist may be able to provide much information about human remains, such as the age and sex of the individual, but may sometimes still draw a blank as to their identity. The detailed dental records of a male body found at the King's Cross fire have been widely circulated amongst the dental profession, however, despite all efforts, he has still not been identified.

The introduction of the latest tooth-coloured restorative materials, and the decreased requirement for restorations in many individuals, are predicted to make the work of the forensic odontologist much more difficult in future. This is because the detection of tooth-coloured restorations are much more difficult, especially in the case of mass disasters. This means their work will become more difficult and will require more elaborate laboratory investigations and back-up in the future. The importance of keeping accurate dental records by dental practitioners was stressed to be of great importance in helping with victim identification. Due to the increased adoption of computers in the dental practice, this task may be speeded up by allowing many patients records to be sorted quickly.

The whole area of victim identification after a mass, or even single disaster, is one that requires sensitivity, professionalism and respect, all qualities which Dr Sims was clearly seen to possess. Dr Sims gave a very interesting lecture, and I am sure it will not be very long before his name appears on the Dental Society Lecture programme again.

Paul Copson
Dental Society Sec

Second Year Hell

The second year of the BMS course is thought by many to be the most difficult. Students have to master neuroanatomy and physiology, begin to do clinical work and consider doing a BSc. Not only are their main exams early—before Easter—but they are expected to be major contributors to hospital social life. Charities week is traditionally planned by the second year and the year is also expected to put on a BMS Review. The second year may be considered the most enjoyable as the naivety and novelty of being a fresher has worn off.

What I ask is that all of us in other years should help those in the second year. Particularly with charities week which will this year be for the 'Children at Guys' and St. Thomas' Hospitals'.

UNION NEWS

The Clubs Union has now bought a 15 seater minibus. This can be hired, for a fee, by any club within UMDS. Drivers will have to be over 21 and are personally responsible for any damage. We hope that this facility will be of benefit to all clubs who travel to fixtures or events.

The medical school is encouraging students to form links with Lille Medical School in France. It is hoped that BSc exchanges and elective visits will eventually be possible for both medical and dental Students.

One idea which has attracted support is that of a weekend away playing sport against Lille. All sports can take part if Lille can provide opposition. If any clubs are interested please do contact me and I will find a suitable date. I must add that costs may be covered by the medical school!

If anyone has any problems please do not hesitate to contact me or any of the union officers.

God Bless You

Richard Russell
Guy's campus president

OBITUARIES

Dorothy Madge Smith

Dorothy Smith died, aged 95. She was born on 14 August 1895, the fifth surviving child of the family of ten born to Walter Smith, who was a farmer, and his wife Eleanor.

In 1916 she went to Guy's.

The Guy's motto is 'Dare quam accipere'—'it is more blessed to give than to receive-—Perhaps a suitable epitaph for Dorothy? But one which she would probably have declined, for she was both shy and modest. Indeed, she would have appreciated the humour of the wag who suggested that the motto applied only to medicines. So, having left the Swaffham family, she joined the Guy's family. Within 3 years she got her strings, and it was not long before she became a Staff Nurse.

By 1927, 11 years after her arrival at Guy's, she was appointed an Assistant Matron. This was to be a short-lived post, for in 1929 she was selected to be Lady Superintendent (Matron) of the Middlesex Hospital.

Dorothy made an immediate impact at the Middlesex by instituting two reforms which now, 60 years later, may seem unremarkable. The first was to move the patients' breakfast time forward from 5 o'clock in the morning to 7 o'clock against an outcry from the Sisters, who said that they would be unable to get the wards ready for the rounds at 9 o'clock. The second was to insist that, in addition to one day off each week, the Sisters must take one weekend off each month. All of us here know her quiet but persuasive personality, and can visualise how she ensured these two reforms were carried through without fuss. Once she had decided on a course of action which she

OBITUARIES

believed to be right, she never wavered in execution.

By 1944, victory against the Germans was in sight. This was the year in which she assumed further responsibilities on being elected to the chairmanship of the General Nursing Council of which she had been a member since 1938. The Nurses Act became law in 1943 and soon after, the seeds were sown for the National Health Act which became a parliamentary bill in 1946, although not implemented until 1948. She presided over the General Nursing Council through those momentous years until 1955 but, as she said in her parting speech, 'whilst we have often argued, we have never quarrelled'. It is a witness to her energy and loyalty that, of the 134 Council meetings held during her period of office, she attended 133, missing one only because she was then giving a lecture on nursing in the United States. She served also as advisor to the RAF Nursing Service and the Nursing Service for Prisons.

In 1946 she was invited (the post was not advertised) to return to Guy's as Matron. She must then have felt war weary. Apart from all else, during the war her younger sister Jess's husband had been killed, and Dorothy had unhesitatingly gone to her succour and accepted the guardianship, should it have been needed, of the three children. She always bore far more than her fair share of responsibility for the then enlarged Swaffham family.

So it was she returned to Guy's as Matron, to succeed Emily MacManus, the incumbent for the previous 20 years. But it was a different Guy's. The Hospital as she had first known it had suffered grievous bomb damage. The whole of the East Wing of the front court had been destroyed, which had formerly contained the lovely rooms of the Treasurer's House, the Court Room, the Counting House and the Superintendent's office, all part of the very fabric and foundation of the original Hospital. Severe damage had been done to many other buildings. The neighbourhood of the Hospital suffered even worse: Immediately to the East seven acres of Southwark had been flattened.

As Hilda Gration—a Sister Tutor—was to write later (on Dorothy's retirement), 'It was not only a love of Guy's, but a real sense of duty which brought her from a new and comparatively orderly hospital to the chaos and dirt of Guy's after the bombing and destruction of the war years. Methodically, and with determination and perseverance, she has played a great part in the reconditioning of the old Hospital and dealt with the nursing and domestic problems entailed by constant changes of wards for cleaning and repairs.'

There was a clear chain of command; clear definitions of people's authority and responsibility with highly effective communications, all based on personal approaches.

> 'A Matron must have a very broad back', she wrote, 'and I think her chief duty is to get the best out of people. I heard a story the other day: Two nurses who had trained at the same hospital, and whose ship had been torpedoed, were clinging to the same piece of wreckage in the Atlantic. One was becoming utterly exhausted and said to her friend "I can't hang on any longer, I am giving up." The other one answered "Oh no, you couldn't, Matron would be furious".'

She retired from Guy's in 1953. She was appointed OBE in 1943 and CBE in 1953.

We shall miss the sparkle of those china blue eyes, the unique four-stroke chuckle,

made with an inward breath, and the sense of simple tranquillity which she brought into the lives of so many. Her favourite parable was the Parable of the Talents, and she certainly used hers in the pursuit of the common good, and towards those who were fortunate enough to know her.

Derek Smith

William Hugh Miller

W H Miller, who was in general practice in Mundesley on the Norfolk coast from 1930 till the early 70's, died on 28 May, 1990. Born on 4 June 1904, he was the younger brother of Frederick Currer Miller, who also trained at Guy's. William Miller went from St Paul's School to Guy's Hospital in 1922, qualifying in 1928. He was awarded the Certificate of Honour (bracketed first) for the Hilton Prize for Dissection in 1925, obtained his MRCS and LRCP in October/November 1927 and his MB BS in December 1928. He became House Surgeon to Mr Mollison, ENT Surgeon at Guy's. He explored general practice through a number of locum situations and took on the Norfolk practice in partnership with Cromer doctors in May 1930. He held general surgery and ENT appointments at Cromer Hospital and was joint author of 'Arthritis Complicating Rubella in a recent Epidemic', published in *The Practitioner* in April 1963.

He was a well-loved family doctor, building up the village practice virtually single-handed. He has received many tributes for his years of caring service, throughout which he had the able support and assistance of his wife, Dorothy (née Davies), a Guy's nurse, whom he married on 1 November 1930, and who survives him. Of their three children, their son, John, also Guy's trained, joined the practice in 1963, when it became independent of Cromer. John now heads the three-partner practice in a newly built Medical Centre.

William Miller's years at Guy's will be remembered particularly for his activities with the Rowing Club. He captained the 1st VIII in 1927/28. He attended the Boat Club Reunion in October 1986, with Dorothy and his elder daughter; Here he renewed his acquaintance with his contemporary, Ernest Huddy, and both were presented with Club ties.

In Norfolk, his many and wide ranging interests included sailing, amateur dramatics, model engineering, music (he was an accomplished pianist) and cine photography. He delighted in the life of his family, which now extends to six grandchildren and two great-grandchildren.

Rugby Club

Guy's 3rd XV v Old Blues, Jan 12, HOP
Lost 3–6

Although rain had fallen heavily during the preceding days, the pitch was drying by the time the teams confronted each other. On the first fifteen pitch, the Guy's team were already under pressure from the League leaders. There were some new faces in the thirds and an unfamiliar look to the pack which has been the strength of this side. In the event, the newcomers set an example.

It was a tough but fair match. The Blues pressed the Guy's side in the first few minutes but excellent blocking and tackling by Dales, Hellier and Willings prevented the larger opposition from rolling toward the Guy's line. The backline also spent much of the initial game in defence. There were fine tackles by Hawker, Henderson and Foley. Guppy kicked out of defence and late into the first half Guy's mounted a series of raids which stopped just short of the line. Efforts by Slade, Farland and Zangouras several times stopped within inches of a try.

Attempts to run the ball were often checked by a wily opposition which played to a lenient referee. His interpretation of offside was wanting. Guys players, both students and graduates, undoubtedly had the academic edge but in cunning they were outplayed. Old Blues kicked a penalty and that was the only score at half-time.

In the second half the Guy's pack established a margin of superiority with several heels against the head and some sturdy lineout work from Slade and Farland. Guppy continued to kick with finesse and managed a difficult penalty. Once again the Guy's players were repeatedly held at the line. The opposition ran with less confidence and resorted to tactical kicking. They gained another penalty and despite frenetic attacks could not add to the score.

It was a narrow defeat and an enjoyable match. The first fifteen also lost narrowly, in a creditable performance. Playing away, the second fifteen won by a convincing margin. The two clubs were evenly matched at every level and it was encouraging to see such spirited performances so soon after the Xmas recess.

Team: C Howell; T Gibson; D Zangouras; A Slade; T Farland; R Dales; S Hellier; M Willings; J Hawker; D Guppy; M Henderson; S Foley; P Fewings (Capt.); D Quick; K Underwood.

Guy's 3rd XV v Raynes Park, Jan 19, Away
Lost 3–30

On paper this was a strong Guy's side. The opposition were fitter, better drilled and more determined. Morning games are rarely won by Guy's possibly because of their proximity to Friday evening. Students work so hard that by Friday they feel compelled to relax and the new bar provides seductive conviviality.

This game was played in a good spirit although the Guy's team seemed more than usually preoccupied. For a start, they turned up with one man less than a full side. Their pack was pushed hither and thither despite the bulk of Popplewell. The front row were contorted and Howell spent his energy wrestling with a prop who knew every disruptive ruse.

The Guy's backs tackled well. Veasey and Guppy relieved the pressure with good kicking but slack passing presented

the opposition with four breakaway tries. Starved of sound possession Fewings, McCarthy and Porter survived off scraps. Every attempt to play open rugby was thwarted by fierce tackling or dropped passes. In the lineout, Rose jumped magnificently but he was poorly supported.

At half time the score was respectable and Guy's still had an opportunity to make amends. Their hearts were not in it. Porter tackled superbly but some sloppy defensive work allowed Raynes Park to add another few tries. Their kicker was in form and nothing went right for Guy's. In a final flourish, their one really penetrating attack ended disastrously when the loose ball was secured by an opposition player who ran three quarters of the pitch to score. It was a game that the third fifteen will want to forget.

Team: C Howell; T Gibson; D Zangouras; M Popplewell; A Rose; M Morgan; N White; D Ryan; J Hawker; D Guppy; M Veasey; J McCarthy; P Fewings (Capt.); A Porter.

UMDS Hockey Club—Guy's Division

The Season So Far

The season started with a whole host of new faces eager to represent us and also with quite a few old ones missing! Initially we got off to a rather poor start with Thames Polytechnic knocking us out of the Kent Cup after the first round. This soon got worse as we started to lose most of our league games (Kent Division II), mostly due to the fact that we were not used to playing as a team. This was not really helped by the fact that most of the clubs were rather difficult to get to, as was shown by the arrival of a few men halfway through one of the matches (well done Shamik, and for future reference London Bridge is a different station to Victoria). The freshers did not let us down and there were some very good performances from the likes of: Sampi 'Jigger' Mehta; Robert 'The Pilot' Hatrick; Guy '?' Barwell and the rather late discovery of Ramesh, our ex-Singapore Schools' goalkeeper, was a very good omen.

Above: Ken Ong in flight.

The UH Cup matches got off to a very good start when we won against The London 3–0. Both Simon Moodie and Tom Brink showed off their remarkable talents

Above: action from the cup match.

both on and off the pitch; Tom with his dove-tail stick carpentry and Simon with his *ad hoc* imbibing qualities. The next round was against St George's and this was at the start of the second half of the season. The match was drawn 2–2 and bad light meant that a replay was necessary.

Eventually the elective boys returned (all with a sick sort of glow to them). Once back they were soon into the swing of things and the first Kent league match after their return was won 4–1 against Edenbridge. It was now time to meet George's again for the replay and the score was drawn 1–1, even after extra time. Penalties were then played and midway through, the ever supple Ken Ong assumed his flamingo stance, as he was not sure of the amount of steps to take. Richard Russell was definitely on form and the penalty score was 3–1 to us. Ken and Richard, not yet content, continued to amuse after the match, having slipped into their characteristic states of incoherency. We now look forward to meeting our sister side in the semi-final and again for the tour. Watch this space for further news.

Gordon Kooiman
Abhi Lall

Guy's & Thomas' Sailing Club

The first appearance of the G&T SC was at the Welsh Harp (near Wembley) on 2 February. The event was the London Inter Collegiate Castaways Cup to be sailed in London's 6 brand new races by college teams of 6 people. The basis of team racing (as regularly pursued by UH & UL) is to get your 3 team boats into the highest positions by displacing the opposing teams boats using the racing rules. This was achieved, despite the summer breeze blowing, with increasing competance towards the end of the day, allowing us to win firstly our league and then the final against UCL to win the cup.

Through the winter, the college club is reasonably inactive, merely raising a team for big events such as these (of UL and others of UH), with UH and UL taking the serious sides to racing. During the summer, the club opens out as a cruising club with organised weekends up at Burnham, based at the UH (HO sleeper) barge with the use of their squibs (20 ft keel dayboats) and our newly revamped dinghies (470, Enterprise and Laser). We also have two Laser II dinghies (spinnaker trapeze boats) which are based at Datchet Water (near Windsor) and may be sailed or raced whenever.

Keep a lookout for events coming up on the noticeboards or contact Phil Ridsdill Smith if you want more information on the club.

Castaways Cup Winners
Phil Ridsdill Smith, Clive Lewis, Tony Gunston, James Read, William Francis, Jane Collyer.

New Doctors

The following students qualified MB BS (London) in December 1990 and are life members of the United Clubs:
BIJLANI, Aisha
HENDERSON, Hugo William Alexander
KING, Richard Ian
MEAD, Andrew James
TERRY, Anne Elizabeth
YU, Christopher Bing On

The following students qualified MB Chir (Cambridge) in December 1990 and are life members of the United Clubs:
MALIK, Igbal Saeed
SANDHU, Kanwaljit Singh

New Dentists

The following students qualified BDS University of London in December 1990 and are life members of the United Clubs.
BAHAR, Arezoo
BUNTING, Simon James
CHAN YUEN HAR, Christine
CROWDY, Phillipa Kate
CUFFIN, Sarah Louisa
DAS, Susmita
DAVIES, John Huw
DAVIES, Sally Christine
DEHGHANIAN, Sima
DHABALIA, Zaki John
DOWNHAM, Lucy Elizabeth*

EVANS, Marie Louise
FAN, Fung Mei Kathleen
FOO, Magdalen Kaow Ling
GHAURI, Sarfraz
GILES, Stephanie Anne
GORDON, Fiona Margaret
GOWERS, Philip Anthony
HALL, Caroline Jane
HALLAM, David John
HASAN, Adam Shawn
HEFFERNAN, Michael Joseph
HEKMAT, Marko
HUGHES, Ceri Wyn*
HUSEYIN, Can Suavi
JATANIA, Minaxi
JONES, Richard Mark* #
KREEGER, Sarah Wendy Frances
LEWIS, Sharon Vivienne
LO, Yim-Sun
MADANI, Mehdi
MILLER, Joceyln Emma MacDonald
MORRICE, Claire Alison
NASH, Alastair John
OSMAN, Naheed
PATEL, Janita Yashvantrai
PHILLIPS, Raquel Valentina
PHILPOT, Nicola Sarah+
PRATER, Neil Barclay
RAFEEK, Reisha Nerissa
RAMSOHOYE, Andrew Michael Vishnu
SMITH, Janine Catherine
STOCKTON, Peter Alexander
TATHAM, Helen Clare
WONG, Bernard Wai Shing
YONG WEN MING, Grace

* Honours in Dental Surgery
\# Honours in Orthodontics and Paedodontics
\+ Honours in Pharmacology and Therapeutics.

Births

STOCK. To Peter and Ann (née Williams, Guy's School of Physiotherapy) a son, James David, brother for William, on 14 June 1989 at St John's Hospital, Chelmsford. A second grandchild for Dr and Mrs Stanley Williams.

Deaths

PARISH, Mary. She trained at Guy's (1916–1921) and was SRN, SCM MCSP. She died at the Retired Nurses National Home, Bournemouth on 2 February, 1991. Grateful thanks for the Christmas presents sent to her by the Nurses' League.
WILLIAMS, Arthur. He was FRCS, FRCOG, and died 31 December, 1990.

Change of Address

KING-TURNER, Elizabeth
'Cedar Heights'
Fernhill,
Oxshott,
Surrey KT22 0JH.
Tel: 0372 843 987

DENMARK, Dr L N
c/o Office of the Chief Medical Examiner,
PO Box 2257
Edmonton, Alberta,
CANADA T5J 2P4.
Tel: 403 4274987
Fax: 403 4221265

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MEDICAL
SCHOOL

GUY'S HOSPITAL GAZETTE
April 1991

24 APR 1991

- The Trust Agenda — challenges for the future
- Flagship Guy's — has it anchored in hope?
- The Snooker Playing Professor — an interview with Prof Tynan

Above: The Queen Mother visiting Ronald McDonald House at Guy's Hospital

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Guy's Gazette

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Volume 105 Number 2411 April 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

Informative though the clinical course generally is, we feel that there is a worrying lack of training or standardisation in the teaching of practical aspects of medicine.

At no point, for instance, during the whole of the clinical course, does anybody check whether competence in siting a Venflon or passing a catheter has been attained. It is quite possible never to have done these by the time of qualifying, and a straw poll of final year students suggest that many of them have indeed never inserted a catheter.

A recent survey of junior doctors in Manchester (*BMJ* 1991:**302**:306) has shown that an alarmingly large percentage did not know that there were catheters for short-term, as opposed to long-term use, or that these catheters had different bores. This sort of fact is learned gradually on the ward, and inevitably to the detriment of the patients.

Similarly, action at a trauma incident is never automatic, even having completed a firm in A&E. Unlike the drilled efficiency of the armed forces, or the constantly updated trauma skills of American students (tested at 5-yearly intervals) we must content ourselves with a 4 week firm, mixed with orthopaedics. It is neither enough time to have a sound theoretical knowledge or be polished enough at the most rudimentary practical skills. Never mind, though! Despite it being standard practice at Guy's A&E to tick the box that says the objectives have *not* been achieved, I have spent two years studying biochemistry. As the fractured maxilla looms into view, I will be able to snap into action and hazily recall a bit of life-saving Krebs' cycle.

It is not enough to expect people to just pick things up. It is much too easy to pick up bad habits in clinical medicine. The end-of-firm MCQ's barely address themselves to the subject being examined, let alone to the practicalities of it.

Perhaps there should be a check-list of procedures to be witnessed and signed for during the clinical course, because we believe that the idea of 'see one, do one, teach one' has drifted from being a classic medical joke to a frightening and potentially harmful reality.

What A Good Idea

Dear Sir,

The letters to the *Gazette* continue to be helpful. I much enjoyed Dr Steer's letter and can assure him that we continue to appreciate the importance of listening rather than talking to patients. I accept Mr Gardiner's criticism about the Ophthalmology teaching and can assure him we recognise its importance and are working hard on improving our arrangements. Mr Richard Russell, Student President, asks us to reconsider the title of our combined School so that the words Guy's and St Thomas's are emphasised and the Council of Governors is considering just such a measure at present.

It was nice to see a letter from my old friend David Cooper and he and others will be pleased to know that we are indeed intending to elect Honorary Fellows. We already have an honorary degree ceremony in Southwark Cathedral and, as he suggests, this will be the ideal time to make these presentations.

Yours faithfully,

C CHANTLER
Clinical Dean

Final Year Ball

Dear Sir,

We are proud to announce the forthcoming Final Year Ball. It will probably be the last Guy's final year ball and we have booked the Waldorf Hotel, Aldwych for Friday 21 June. Included in the evening will be a reception, three course meal, wine, live band and disco, and we hope to organise a final year photo to be taken at the reception.

We anticipate and hope the majority of the year will attend and, as such, have reserved tickets for all final year students (and guest if desired). Tickets will be on sale during the six week revision period, but if you have any questions you can contact us via the final year ball pigeon hole on the first floor of Boland House.

Happy cramming.

Yours faithfully,

ANDY WILLIAMS
REBECCA LEWIS
EMMA ROSS
LADE SMITH

Post Room Blues

Dear Sir,

It may be of comfort to members of the Hospital to find that, no matter how bad their day, things could be worse—they could be working in the Post Room. In the Post Room vowel sounds must have been banned, because workers there communicate by using a complex series of grunts and hand signals. Laughter must also be forbidden since the men wear perpetual scowls and no sounds of amusement can be heard, even during their extended lunch breaks.

I have great admiration for these men who are prepared to sacrifice their own pleasure to ensure that the Post Room maintains its legendary reputation.

Yours faithfully,

OLIVER JAMES
Boland House

Congratulations

Dear Sir,

Congratulations on your good sense and taste in reverting to the 'old style' format of the *Gazette*. It was always a convenient size and shape and looks attractive—particularly with the crest on the cover. Please don't ever change it again for change sake. We can all now look forward with pleasure to receiving the *Gazette*.

Yours faithfully,

Dr W P N MOORE
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Gundleton,
Alresford
Hants.

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Guy's Overspent

Guy's is overspent by £206,000 at the end of the ninth month in the financial year. The overall position remains poor, and a year end position of £1.4 million overspent is predicted.

Exploitation of Juniors

Teaching hospitals have been told that they will lose educational approval for training posts if they carry on exploiting junior doctors.

The warning comes from London University, which is responsible for a quarter of the pre-registration posts in England and Wales.

It says juniors should not be used as porters, clerks, technicians or bed-hunters and describes such duties as 'totally inappropriate and unacceptable for house officers'.

Guy's RFC 200 Club

At the Rugby Club Committee meeting on February 5, the winner of the 200 Club draw was Dr D Gullick, 1 Heathbrow Road, Welwyn, Herts.

A case of wine is awarded to the winners of the draw which takes place every month during the season. Bankers order forms for membership of the Club can be obtained from Dr T Gibson, Guy's Hospital.

New Appointments at Guy's

The Board of Governors of the United Medical and Dental Schools have made the following appointments:

Professor F P Ashley to be Dean of the Dental School for five years from 1 August and head of the Department of Periodontology and Preventive Dentistry from 1 October.

Professor Ashley qualified in Manchester in 1964. After a period in general practice he was appointed as a Research Assistant at Guy's Dental School in 1968. He obtained the FDS and PhD and in due course was appointed Professor of Periodontology and Preventive Dentistry in 1984. For 5 years he was Assistant Scientific Editor of the *British Dental Journal* and now sits on the Editorial Board. He was Chairman of the Dental Health Advisory Panel 1984–90 and the Health Education Council 1984–87. Professor Ashley is well known for his epidemiological and plaque studies.

Dr B G N Smith to be Head of the Department of Conservative Dental Surgery. Dr Smith is at present Reader in Conservative Dental Surgery at the Dental School. He taught at the London, University College and the Royal before coming to Guy's as a Senior Lecturer in 1983. He was promoted to Reader in 1986. He is in great demand as a lecturer on Restorative Dentistry and has published widely. His book *Crowns and Bridges* has received wide acclaim.

These appointments arise because of the impending retirements of Professor A H R Rowe and Professor M N Naylor.

Queen Mother Visits Guy's

The Queen Mother visited Ronald McDonald House on 13 February. The Trustees were delighted that she honoured the House and unveiled a sundial to commemorate the occasion. The Queen Mother met a number of families staying at the House and listened to their experiences.

For more information about the House, which is unique in Britain to Guy's, telephone (071) 403 3263.

NHS Support Federation Fights On

The Chairman of the NHS Support Federation (FED), Professor Harry Keen, has said that the organisation will continue to battle against the NHS reforms. 'It is vital that we keep the pressure up', he said. 'We will go on arguing to protect and improve the Health Service until we win. It's too important an issue not to . . . we will not go away'.

Strollerthon

Cadbury's, the confectioner, have agreed to sponsor the Strollerthon to be held in aid of the Gait Laboratory later this year. They have also asked that the laboratory be linked with, and named after, their *Strollers* product.

Building Progress at Guy's

The weather during February succeeded where even 'the Bomb that never was' failed—it stopped work on the site for about one week. Even so progress is obvious; we have got used to the new bridge in its startling new livery of green, chosen by Southwark; Great Maze Pond has ceased being dug up every day, even if it still looks like a bomb site. Even Wolfson House residents are not suffering quite as badly as they have done over the last few months. Work on the link corridors is nearly finished. Things are looking up.

Up is the operative word for this Spring; this is when the site will stop looking like a giant concrete-filled bunker and take on the shape of a real building.

There is however a considerable amount of noisy work to be done on the outside of the Tower to prepare it for its union with Philip Harris House. To conjoin the building means further scabbling with drills and other noisy equipment. This will cause noise and vibration to users on floors 1–5 of the Tower. Members of the Project Team will be discussing the problem with people working in the areas affected. At the same time they will be discussing with the project Managers and others the best way of reducing the nuisance.

Theo King

Guy's KPA Abseil' 91

The Guy's Kidney Patient Association, which has so far raised £680,000 towards its £1m appeal for the new kidney unit, need 1,200 volunteers to jump off a 327 foot office block. They plan to have 1,200 people abseil down Price Waterhouse's Southwark Towers from 12 noon Saturday 22 June to 12 noon Sunday 23 June. The abseil will be closely supervised by HM Royal Marine Commandos and is the biggest event of its kind ever staged.

All those interested should contact Mr Eric Martin, 134 Purley Downs Road, Sanderstead, Surrey, CRZ ORE (Tel: (081) 657 1815).

The Bomb That Never Was

On 10 January 1991 the contractor started to bore the last main grid pile No 445 in the area to the east of Guy's Tower. Having reached a depth of 3.5–4 metres, the auger hit an obstruction. Instructions were issued for an investigation which commenced the following morning. It transpired that the piling operator had encountered a similar obstruction on another site in this area which turned out to be an unexploded World War II bomb. In view of this, the contractor consulted their Safety Department who in turn contacted the Metropolitan Police. From the records held by C13 Branch, the police considered that the evidence fitted the pattern of unexploded bombs in the area and promptly classified the incident as potentially dangerous, referring the problem to the Army.

21 EOD Squadron RE under the command of Major Jon Watkins, RE, took possession of that part of the site on the evening of 11 January 1991. They drilled holes down to the level of the obstruction and lowered sensitive magnetic recording equipment. This revealed the existence of a linear metallic object at about 3.8 metres below the surface in an approximately vertical position possibly up to 1.5 metres long. The trace led them to believe that they were faced with a 2,000 lb bomb, with a 90% degree of certainty.

On Monday 14 January 1991, discussion took place between the Army, Project Manager, WGI, Structural Engineers and the contractor as to how best to excavate the area, firstly to prove whether or not it was a bomb and, if so, to drill out the fuse and remove the explosive. The principle problem was water which continually flooded the excavation. Various possibilities were proposed and the Army utilised the specialist dewatering contractor already on site to instal dewatering equipment and large pumps.Eventually the limitations of the military equipment became clear and they opted to fall back on the old military principle of two men equipped with what are known as 'Shovels RE'.

Digging continued round the clock until 16 January 1991 when it was discovered that the 'bomb' was a length of steel tube filled with concrete and having the remains of steel guy ropes attached. It can only be assumed that it was an anchor left behind after Guy's Tower was constructed. On the way down to the device, the Army encountered several lumps of congealed aggregate which when analysed were diagnosed as a primitive form of concrete, probably Roman. Further proof of the long history of Guy's site.

The army finally left the site on 18 January 1991, having found nothing to go 'bang' but very much the wiser about digging holes in this part of London, especially as they eventually came to realise that they had been trying to pump the Thames dry!

Noel Glover

A memorial service for Mr Noel Glover will be held on 30 April at 12 noon in the Guy's Hospital Chapel.

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The Trust Agenda

by Peter Griffiths, Chief Executive, Guy's & Lewisham Trust

Originally this article was to be the other half of a debate with Professor Grahame on the benefits of Trust status. Fortunately it soon became apparent that such a debate was no longer relevant. Of course the benefits of Trusts still have to be realised—the proof of the pudding is in the eating, but as from 1 April we are a Trust and the debate must move on. The question is not—'will Trusts, **in general**, benefit patients?'. The question is—'how are we going to make sure that **this** Trust benefits the community it serves and its patients and staff?'

As the Chief Executive of the Trust what are my hopes about the management of the Trust? I want the way we work together in becoming the best at everything we do to be:

- Focused
- Flexible
- Friendly
- Fun

What might this mean?

We Are Focused

We are clear about what we are seeking to achieve. We have clear priorities, aspirations and plans. We are realistic about the environment in which we work—the expectations of our community, patients and purchasers, the concerns of politicians and pressure groups. But within these constraints, we have a management perspective that provides us with values and direction, so that:

- quality of service and seeking constant improvement drives us
- we get the basics right, eg patients' transport, car parking, internal mail, signposting, as well as clinical care
- we respond to patients' concerns and views—we are regarded as 'patient-friendly' hospitals
- we respond to employees' concerns and aspirations—we are regarded by our 6000 employees as a good employer
- we strive to be 'the best in class' in everything we do—we are a centre of clinical and managerial excellence

- we compete in everything we do but only to better the quality, quantity and cost effectiveness of our work
- we attract and retain the best staff

We Are Flexible

We accept that change is with us all the time. Management is change. We are adaptive, innovative and responsive to the needs of the people we serve. We challenge thinking that may be rooted in the past. We may have more than one boss and work in teams and task forces. We try things and take risks, accepting that we learn from failures as well as successes. We seek improvements in everything we do. We are concerned with getting things done. As one management guru, Tom Peters, put it 'don't stand there, do something.' This may not be an organisation that will be comfortable for managers and staff who seek stability and certainty. It is flexible because it is constantly adapting to new needs and ideas.

We Are Friendly And Fun

This is a great place to work. People support each other and don't score points. Professional barriers are broken down. The management cares, really cares about people, about their staff and colleagues. The patients think it is a friendly place. There is a St Olave's/New Cross feel about Guy's and Lewisham. Staff have time for patients and their relatives, and listen—managers have time for their staff. Having fun is considered as legitimate!

These then are some initial thoughts on what kind of organisation I hope we will become. Clearly, however, there are immediate problems that have to be tackled.

We have too many people chasing too few resources. The head is too large for the rest of the body to support. If this continues it means continuing financial crisis and straining at the limits everywhere. The jam being too thinly spread everywhere.

We need to be much clearer about what are the services we support and encourage, and inevitably what are the services we reduce or even eliminate.

We need to look at our quality and costs of services if we are to survive in an increasingly competitive health care environment, particularly in London.

We need to generate sufficient financial flexibility:

- to re-invest in staff terms and conditions, emphasising quality more than numbers
- to re-invest in maintenance and the working environment
- to re-invest in those patient care services that we have decided must flourish
- to avoid constant preoccupation with money

Creating this financial flexibility can only come by a significant reduction in our costs and a reduction of our resources to our areas of priority. This process will inevitably be painful over the next twelve months.

Conclusion

We have enormous potential in the names and reputations of our hospitals. We have enormous potential in the basic quality of our patient services, teaching and research. We have extra-ordinary commitment to the NHS from our workforce, and considerable managerial talent. As a Trust we have greater freedoms to respond positively to our own agenda.

The challenge now is: can we tackle the undoubted problems that face us, but in a way that improves the relevance of what we do to our community and the quality of service to our individual patients?

Peter Griffiths

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These are some of the larger items, there were numerous small awards.

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The Flagship Weighs Anchor

Our Trust in the NHS?

On April 1 1991 Guy's Hospital became an NHS Trust. On that day Mr Guy's Hospital passed from the control of the Lewisham and North Southwark Health Authority to that of a Trust Board, each member of which has been hand-picked by the Secretary of State. It will effectively be run by one man, Mr Peter Griffiths, the Chief Executive, newly returned from Richmond House. This brings to fruition a carefully laid and adeptly executed plan, conceived well before the publication of the White Paper in January 1989[1]. Many consultants opposed Trust status, but when it came to the crunch a majority (not including myself) voted in favour. They felt that in the existing political climate it was the best way to protect Guy's future. There were seductive hints of extra funds to ensure financial viability, if Guy's joined the first wave of opt out hospitals. These funds have never materialised.

What will Trust status mean for patients, for staff, for the work of the Hospital?

The most obvious and immediate change will be in the way the Hospital is financed. Instead of money being allocated to Guy's by the region it will all have to be earned by the work we do. The Guy's Trust Finance Officer, Mr Peter Burroughs, will have to win contracts from purchasing authorities. These may be Districts, larger consortia representing groups of merged Districts, or budget-holding GP's. For the Trust to prosper it will need to secure contracts not only from our own local purchasing authority but also from anyone else who is willing to pay. That includes the private sector and overseas interests. The recently-concluded £3m deal with the Saudi Arabian Ministry of Defence and Aviation to buy our clinical and managerial expertise for the benefit of two Saudi military hospitals is part of that strategy. Guy's can only survive as a Trust if its life-blood, the contracts, are forged with all those Districts, which traditionally have referred patients to us. To date we have little information on how well the process is going, nor on the robustness of the commitments already received.

What would we like the Trust to achieve?

We all wish to see our Hospital flourish. Nobody can be happy with the way things have gone in recent years. An increasing gap between our level of funding and our ability to maintain even a basic service has led to closure of wards and operating theatres and an enormous backlog of maintenance work. It is difficult to sustain the high reputation that we once had. GP's complain to me about the difficulties they have in trying to get acutely ill local patients into Guy's and how local women requiring terminations are being turned away. The state of our wards and clinics, our waiting areas (even our loos!) compare very unfavourably with accepted norms. All this, in spite of having the best managers and the most advanced systems of management and information technology available in the NHS. Our nurses are harassed, their morale is low and turn-over high. There is little enthusiasm amongst our junior doctors for a career in hospital work and many of our finest graduates opt for general practice.

It was for these reasons (and because of an unwillingness on the part of government to fund the Service to a degree commensurate with that of our European neighbours), you will recall, that the Reforms came about.

The protagonists of Trust status believe that the new arrangements offer a better chance of rectifying these deficiencies than if Guy's were to remain a District Managed Unit (DMU).

Will it work?

We cannot assume that our past reputation will be sufficient to ensure the flow of contracts on which our income will be based. Not even the glossiest brochure will substitute for patient satisfaction. Unfortunately patients will have a rather remote voice in these matters, since most decisions on contracts will be made by mega-consortia, a few by GPs, and none at all by the patients or their representatives. In the new Trust, Mrs Gillian Mallinson, a non-executive Board member, has been given the all-important task of protecting patients' interests. All power to her elbow!

Purchasing authorities, however, are likely to be more concerned with price than with quality, since (in inner city areas) they will immediately face a reduced budget with which to procure the same volume of care. My concern is that faced with these financial pressures, purchasers, from whose areas patients have traditionally come to Guy's, will be forced to buy their own cheaper local services in order to conserve their resources on the one hand, and in order to ensure the survival of their own DMUs on the other. The only option left to us then would be to lower our prices still further. We are already under pressure to consider ways and means of how we might achieve just that. Should the Trust adopt the John Lewis motto '*We Are Never Knowingly*

Undersold'? An admirable slogan for a department store, but is it realistic for a central London hospital on an expensive site and with such high overheads? This leads to a consideration of the other side of the Balance Sheet, namely **expenditure**.

The Trust has clearly invested heavily in its human resource infra-structure. It has gone both for quality and quantity. In regard to quality the Trust has already come in for a rebuke from Mr Waldegrave, 'My view of the future does not include pay spirals for those at the very top'[2].

In regard to quantity, in the run up to the Trust we came third highest in the national league for the number of new administrator posts advertised in the six month period between May and October 1990[3]. Our 22 new posts (for this period alone) represent a massive increase in the cost of administering Guy's. No doubt this will be closely scrutinised by the Trust.

Below: Thomas Guy (portrait in ivory relief)

How will the Trust's performance be monitored?

The costs of running the Trust, as well as those of developing our services, will have to be balanced against income. The quality of patient care must also be safeguarded. Since the Trust is accountable only to the Secretary of State there is no external body charged with monitoring its performance. This must be a matter of grave concern to us all. To partially redress this omission a Trust Charter was attached to the Guy's Trust application.

This states: '*As an NHS Trust we guarantee to provide local NHS care to local people; we will continue to teach new generations of doctors and nurses; we will intensify research for the benefit of our future patients; and we will value and reward everyone who works in our services.*' No doubt these are worthy goals, but will they withstand the pressures of the internal market? To ensure compliance with the Charter, the Medical and Dental Committee elected a watch-dog Standing Committee (composed of Drs Bob Knight, Margaret Heath and Gordon Jackson, Mr Bill Owen, Professors Stewart Cameron, Gwyn Williams and myself) charged with the responsibility of monitoring the Trust and of advising the parent committee if it became clear that the terms of the Charter were being breached.

Those of us who opposed the idea of Trust status are determined that Guy's will flourish despite the changed conditions. Sir Philip Harris and his Board carry a heavy burden of responsibility for the success of the Trust. For the sake of Guy's Hospital, its patients, its students and its staff, we hope they succeed.

Rodney Grahame
Professor of Clinical Rheumatology

References:

1 The Flagship—whose hand on the tiller? R Grahame. *Guy's Hospital Gazette* 1989: **103** (2395); 303–306
2 'Waldegrave: No huge pay rises'. *Health Service Journal* 24 January 1991 p 9
3 £80 million management explosion. C Meek. *BMA News Review* 1991 **17**(3); 11–12

The Tynan Interview

A chat with the professor of paediatric cardiology

Professor Tynan's warm welcome into his small eleventh floor office has the effect of putting you immediately at ease. Here is a man who has a serious side to him, but certainly does not take himself too seriously. The burning ambition in his life is to score a break of 50 at snooker, and he is kept awake at night wondering how to work his home computer without actually reading the instructions.

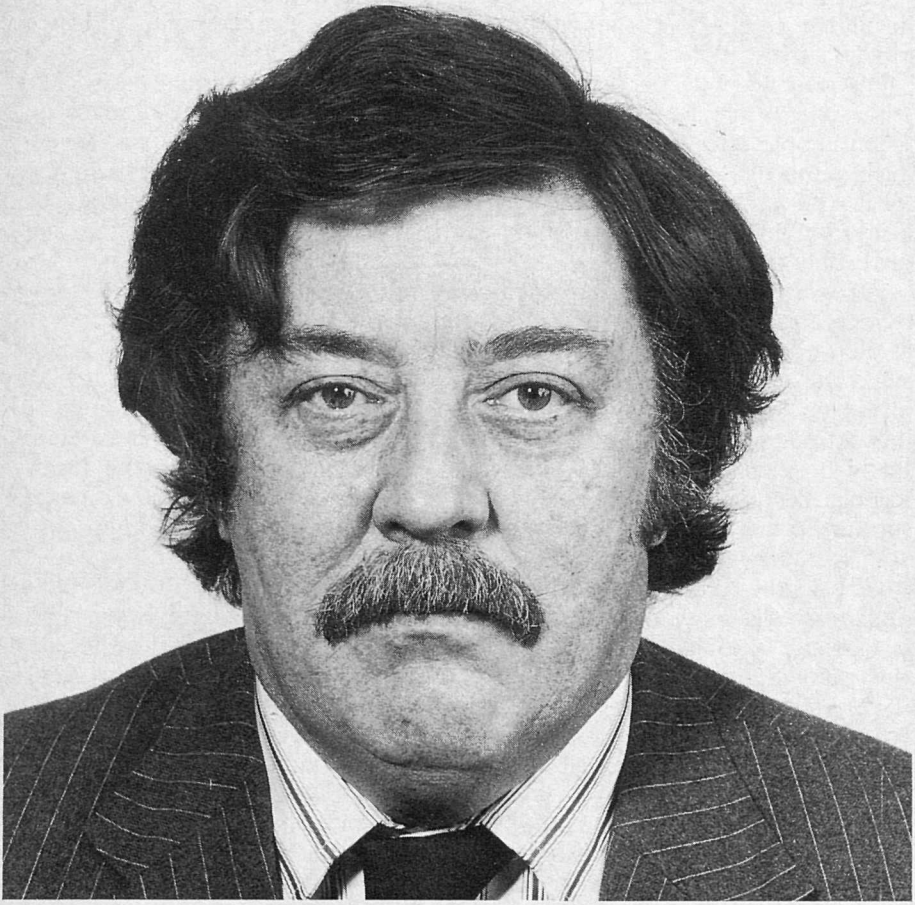
Getting into paediatric cardiology was something of a fluke for him. 'I had a career that was going nowhere. I wasn't a very good student and didn't get a job at my teaching hospital (The London), so after three house jobs I moved to the United States. The second appointment there was an extremely good one at a children's hospital in Boston. When I came back I got a job as paediatric registrar at The Westminster Hospital, which at the time was good at paediatric cardiology. As so often happens, when you know a little bit of a speciality, the easiest job to get is to continue down that path, so after 5 years of paediatric cardiology (now at Great Ormond Street) I was subsequently unemployable in anything else.

'It was interesting, really interesting. It was a subject that was still growing here. There were more paediatric cardiologists in one street in Chicago than there were in Europe. I had the advantage of getting in at just the right time.'

Did he feel that he could use his expertise to the fullest extent in England compared with the USA? For him it was a question of what was technically possible and what was socially desirable—he was brought up in the NHS and never really considered working anywhere else. When it came to the crunch, he chose Newcastle instead of Chicago.

About getting on in medicine, persistence and motivation he feels, are by far the most important. If you just won't go away, they have to give you the job. But was motivation not synonymous with work?

'The problem with being a medical student is that nobody actually knows what you should be doing. Should it be purely training or an intense intellectual experience? I feel that the medical education has always been a bit unfocused. You're working against a system, for an exam coming up or for some work to be handed in and there is such a quantity of work, particularly for students now, that the work is necessarily unfocused. As soon as you start working in your job, you realise how ignorant you are. You have to sit down and do some work and then the motivation becomes important.'



Above: Professor Tynan shows he has a serious side

Professor Tynan's academic career was not by any means a classic rise up the ladder. He claims that he did not dodge the MRCP, rather gave it a desultory try (he eventually did pass the Part I but never took Part II). It seemed of little importance since he was already in his chosen career.

'Paediatric cardiology is a very direct subject. Its anatomy and plumbing, and you get an answer very quickly. The tests are direct, not a few steps removed from what's happening, so you don't need to be very bright to understand it.'

Yet certainly the public perceive it as a very glamorous profession. Tabloid headlines often shout about the brilliance of top cardiac surgeons saving toddler's lives. Professor Tynan is fairly nonplussed by this.

'It's only recently become glamorous. Glamour is traditionally associated with surgeons—people don't think physicians can be exciting things—and when people refer to us like that, they call us surgeons. I guess we do get a lot of publicity, and I suppose we don't shrink from it. Yet I don't really look for it. The job is interesting enough. The excitement is in doing it rather than in the publicity. If we do anything in the way of publicity, we try and raise the profile of the unit.'

His worry is that the paediatric wards, Rothschild and Dickens, may have to merge to help balance the books. He is reluctant to lay the blame directly at the department of health. The problem is not new. It has been going on since the early eighties, with beds closing or under threat of closure. The problem, he is told, is overspending. He claims it to be underfunding. The present dilemma does not have to do directly with being under Trust Status. Every hospital in the country has to come in on budget, and the Evelina Appeal, set up in the early eighties, will hopefully provide some financial support to this end. In fact, Professor Tynan would much rather keep out of administration and get on with the job.

He sees the future of paediatric cardiology as very exciting. It is becoming less invasive, as new techniques enter the repertoire of paediatric cardiologists, but also he feels that pre-natal detection will reduce the size of the speciality, since it will reduce the incidence of complex heart disease—in a secular society like England, 70% of mothers opt for termination rather than put their child through major surgery with no guarantee of success.

After these thoughts, we talk about Professor Tynan off-duty. The man who gets withdrawal symptoms if he doesn't play snooker at least once a week, his wife accompanying, down at the club in Camberwell. He muses that his only unsolicited honour was free membership of this snooker club.

He collects paintings and sculptures, and listens to music—classical, jazz and 'recycled pop' that was popular in his day. If I had an image in my mind of what a typical professor was like, this would not be it. Is he, I wonder, a rebel or conformist?

'I like to think I'm a bit rebellious, but my wife thinks I'm a total conformist,' he laughs.

Eventually, he decides that he is probably a rebel who asks permission first.

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Frothblowers, Astronomers and Billiard Balls

Anecdotes and memoirs from seventy years

House officers today are horrified to hear that in my day they were unpaid; we had full board and our rooms, but that was all. We did, however, make a little money in other ways. For example, we used to assist at operations on private patients and were also required to write reports on patients, mostly accident cases, by firms of solicitors, for which the usual fee was three guineas.

The mention of accidents reminds me that during take-in week we nearly always had at least one fatal accident, for which a Coroner's Court enquiry was called. We had to attend the *post mortem* and give evidence in such cases for which again, we received three guineas. Well, three pounds as the coroner's officer, a police sergeant, always managed to retain the odd shillings—an old Spanish custom!

What couldn't we do with three pounds in those days!

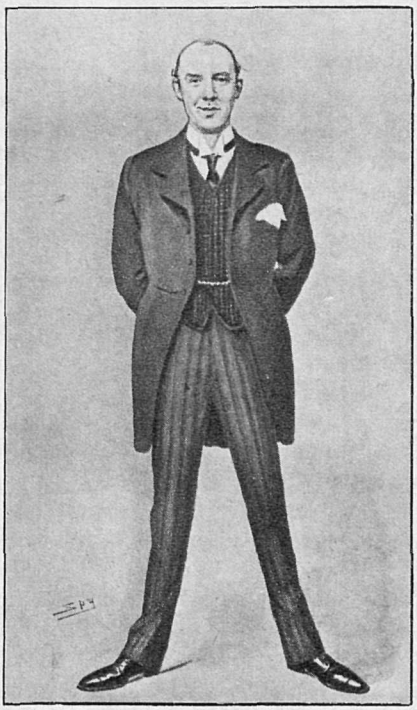
We would go to see Whitbread, the tall distinguished hall porter at the Front Lodge, in his magnificent green frock coat, trimmed with gold braid and his top hat with the gold ribbon, and ask what theatre tickets were available. Sir Alfred Fripp, the Senior Surgeon at Guy's, was honorary surgeon to the acting profession and so theatre tickets were often available for shows that were not attracting full houses. He would ask whether we were wearing dinner jackets, if so we got tickets for the stalls or dress circle. Armed with three pounds, and the tickets, we would next enquire whether our favourite nurse would be off duty on the night.

My pretty nurse and I would then get a bus from London Bridge to Soho, where we could have quite a good dinner in one of the smaller restaurants for about three shillings, including a glass of wine—greatly daring. We would walk to the theatre, I would provide a box of chocolates and a programme—one and sixpence—and after the show we would walk to the Trocadero for dancing and the cabaret at eleven o'clock (very expensive, say four shillings each). If we were lucky we would catch one of the two or three Hansom cabs which plied for fares at that time, and be driven back to the Hospital by

wooden doors in front and the cabby astern and above. I remember it was absolutely *de rigueur* to wear an opera hat on such occasions.

Sir Alfred Fripp founded the 'Frothblowers', a charity organisation. It cost five shillings to join and you were given a small book of rules, including the Frothblowers Anthem, and a pair of cuff links, which were rather smart—oblong with 'FB' in blue enamel. The challenge was 'shoot your cuffs' and if you were not wearing your cuff links you were immediately penalised—which usually meant providing beer for other Frothblowers present. It was a harmless but, at times, tedious nonsense. But it raised an enormous amount for charity as it took on like wildfire all over London.

Below: Sir Alfred Fripp, Surgeon, 1897–1925 (cartoon taken from *Vanity Fair*)



Take-in week was a gruelling time for the firm, particularly the HS, as we were on duty day and night and had to deal with up to forty admissions. These included such things as acute osteomyelitis, appendicitis, bowel obstruction and compound fractures. I was always distressed to admit a case of acute osteomyelitis, usually in a small child, because it meant an extensive exposure of the medullary cavity of a long bone, weeks in hospital and daily dressings which I loathed. Thank goodness it is never seen nowadays. I well remember a very emaciated boy of about seven being admitted with an abdominal mass which defied diagnosis. At laparotomy he was found to be riddled with actinomycosis. I don't suppose current medical students have even heard of the condition. From my experience of that patient, I hope they never will.

Curious things have been inserted into one or other of the eight orifices in the human body and we had our share of them, although the celebrated 'Bust of Napoleon' was not at Guy's. One hero presented himself at Guy's with a long hatpin lost in his urethra. He was given an anaesthetic, a urethoscope was passed and the sharp end of the pin manipulated out of the mucosa. When asked how the pin got there his reply was: 'I was just cleaning out in the usual way, Doctor'. One lives and learns. I remember too, the story of the candidate asked the differential diagnosis of a swelling the size of a billard ball in the vault of the vagina. He answered, quite correctly: 'It might be a billiard ball, Sir.'

The take-in HS had a week in which to draw his breath after sleepless nights, long sessions of take-in firm suppers (sausages and beer) and some forty ill patients, and then he became the ex-HS and was responsible for giving anaesthetics for the new take-in firm at night.

It was the custom for HO's to await the arrival of their chiefs at the entrance to the colonnade. One afternoon I was there waiting for Philip Turner, when a Rolls Royce drove to the steps, followed by a taxi. From the Rolls, Herbert French descended, immaculate in a grey morning suit and top hat; from the taxi emerged Reggie Waterfield, French's HP, arrayed in a spectacular black morning coat, with a wide braid edging—very *bon ton*—striped black trousers, highly polished boots with white spats—very fashionable then—and carrying a silk hat. They walked up the steps together. It was a magnificent and unforgettable spectacle. French looked a bit boot-faced, but Reggie was not in the least embarrassed. He had just attended a fashionable wedding. Reggie was a remarkable man. Apart from being rather good at medicine, he was the youngest Fellow of the Royal Astronomical Society and wrote a book entitled '*A Hundred Years of Astronomy*' when he was a house officer. He was an accomplished pianist, and once astounded the Hospital, by having a piano installed in his room. But he played quietly and I remember many happy evenings singing, with him at the piano. His father was the Dean of

Above: 'The Niggers', Christmas 1927

Chester, and he used to refer to his parents as the 'Holy Family'. It was often said that Reggie had cards printed which read, 'Dr R L Waterfield does nothing for nothing; and very little for sixpence', and that he used to send these to solicitors who did not pay his fees. Quite like him, but the story is probably apocryphal.

After the war, Reggie suffered a devastating attack of poliomyelitis. I remember him with both affection and amusement—he was one of the great eccentrics.

On Christmas Day the Residents and the six Clinicals dressed up in fancy dress to form 'The Disguised Minstrels' or, more familiarly, 'The Niggers'. Each HO was required to sing a song in each of his two wards. One of my contemporaries, L R B Birt, was the only man I ever met who was completely tone deaf, and his rendering of '*She wouldn't do what I asked her to so I shan't ask her no more*', was excruciating. The patients of course loved it, and he was repeatedly encored. Whatever note he started on, he and the piano never once coincided. I met LRB in Johannesburg many years later, and he was the same cheerfully delightful chap, but we didn't persuade him to sing. When I was a Clinical, we six formed a concert party at Christmas and were invited to perform at a small local hospital; but with so much singing we had completely lost our voices. Tom Bonner, the Senior Surgical Registrar

who always rehearsed The Niggers, came to our rescue. About fifteen minutes before we were due to sing he treated our throats with a cocaine spray, with dramatic success. But the effects were ephemeral—we were speechless again within the hour.

I was also cajoled into writing the Residents' Play, in which members of the senior staff were portrayed and lampooned. It was quite an ambitious production and Fox's, the wigmakers, sent a man to take notes of the peculiarites of certain characters' hair styles. He was invited to lunch in the College when some members of the staff would be having a meal. The Hospital Works Department went to great trouble to erect the stage and construct special effects. Oliver Ive, whom I saw about a year ago looking as young as ever, wrote some memorable music for the songs and played brilliantly for every performance. My great fear was that he'd break a leg or something because no music was written down and without him the show could not go on. The plot of the play was quite irrelevant; it was merely a mechanism to have fun at the expense of the staff. One of the songs was directed at Trethowan—Tregarlan in the play—and was well received. Here's the first verse:

'As an orthodoedician or cunning clinician
You've doubtless heard of Tregowlan—that's me.
For bony deformities or abnormalities
The surgeon to visit is certainly me.
I know all the tricks of the wily bone setter.
I get all his failures and make them all better.
I twist them and bend them, I crack them and rend them.
They worship the name of Tregowlan—that's me'.

To a cheery Gilbert and Sullivan kind of tune it went down well.

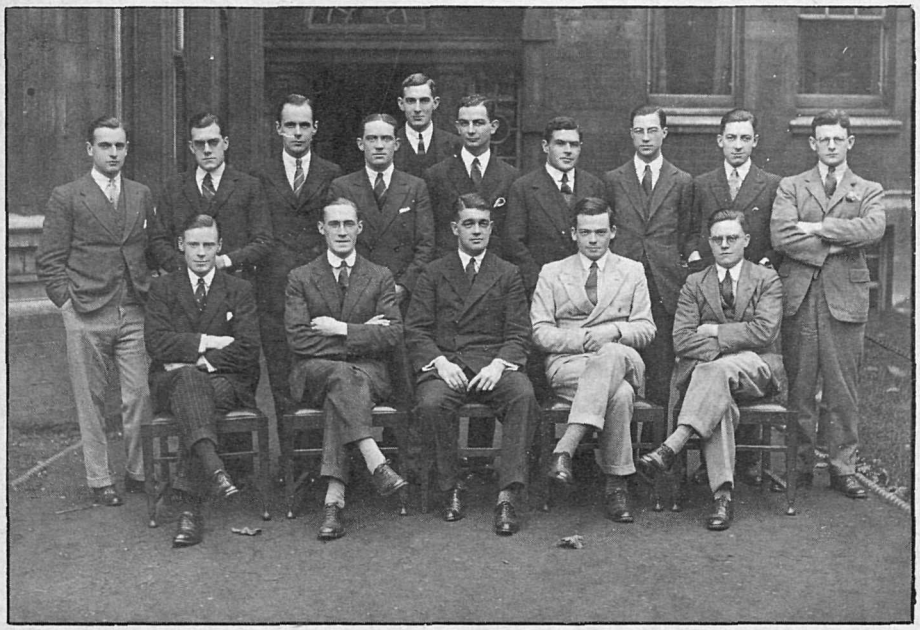
S C H Lane and I produced the play. Rehearsals were awful, and the dress rehearsal more like a *bierfest*, but it wasn't too bad on the night.

I recall two other stories about Christmas; the first was of a patient in the medical wards recovering from a gastric ulcer, and who was on a strict diet, who was given a tiny piece of Christmas pudding. A repeat X-ray after Christmas was taken and the radiologist's report read: 'Gastric ulcer smaller, but what about the horse shoe?'

The other, at a hospital near Guy's, was of a chap who turned up rather drunk at casualty saying he'd swallowed a fork. The casualty officer pooh-poohed the idea and said come tomorrow and we'll see you again. He still persisted that he'd swallowed a fork so he was X-rayed, and he had!

And so, after seven years, I left Guy's with no notion of what I intended to do next, apart from taking a holiday, I hoped. But that had to be postponed, for I had hardly returned to the bosom of my family when the telephone rang

Below: Guy's Hospital Resident Staff, 1927



J M Turner
F G Parker, N H Allen, F J Sale, E J Pye-Smith, R Jarman, E H Roche, S R Trick, E D Y Grasby, D M N Ettles
G T Hankey, R C Brock, L S Williams, L R B Birt, J G Weston

and the call was for me. A friend of the family, a GP in Gillingham, 'phoned in despair. He was going to Switzerland that evening on a skiing holiday and his locum had just been delivered by taxi to his house, blind drunk! He had been put back in the taxi and sent back to London. Dr X, as we'll call him, was distraught but knew I was coming home. Would I undertake his practice for two weeks? Mrs X was also a doctor but had recently had a baby which prevented her from going skiing and from taking part in the practice.

I knew nothing of general practice, had no wish to acquire any such knowledge and had only one desire—to have a bit of a rest. However, they were so desperate, and so persuasive, that I agreed.

to be continued

E D Y Grasby

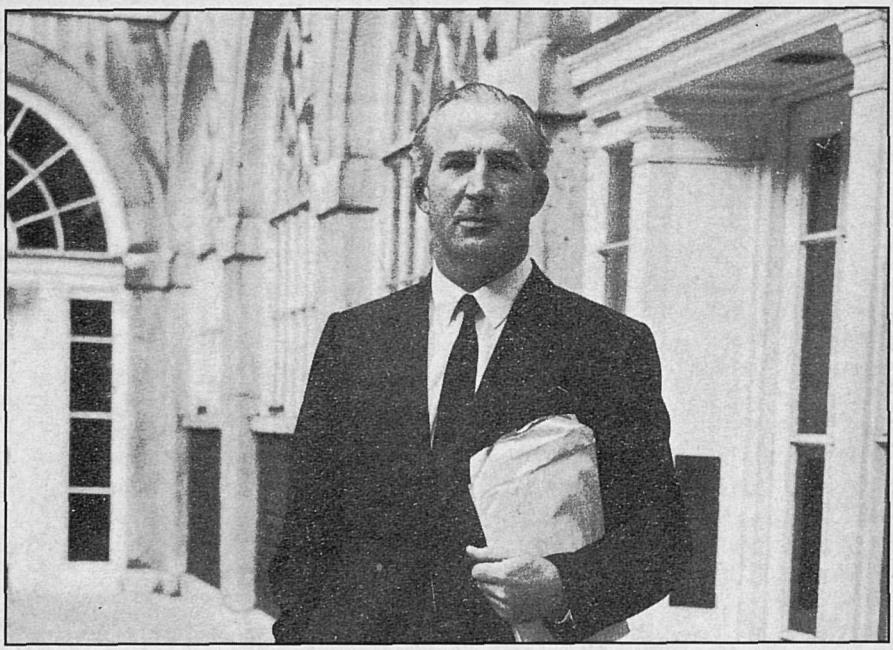
FN Glover MS, FRCS

Noel Glover, Consultant Surgeon Emeritus to Guy's Hospital died on 4 January, aged 73 years, after a long illness.

He was the son of a Guy's dentist, F S Glover, who came to Guy's from New Zealand and was appointed to the staff of the London Hospital. After education at Dulwich College, Noel entered the Medical School at Guy's in 1934 and graduated MB, BS in 1939. A brilliant student, he was one of the few people who obtained the Primary Fellowship at the same time as he took his 2nd MB. He became a Fellow of the Royal College of Surgeons in 1942 and in the following year obtained his MS.

The Second World War started within a few weeks of his graduation but, in September 1939, he was appointed Assistant House Physician at Guy's to Drs Poulton and Grant. He followed this as House Surgeon to Sir Heneage Ogilvie and in 1941 became Registrar to Sir Hedley Atkins and later to Nils Eckhoff, from whom Noel learned a great deal of Nils' excellent surgical technique. At the same time he was Surgical Tutor to the Preclinical Class.

Together with S H Wass and F R Kilpatrick, he helped carry the surgical side of Guy's through the Blitz, but, like them, was faced with the awful dilemma of whether he ought to join the Forces or help maintain the absolutely essential



service the Hospital was providing. Eventually the problem was solved when he was called up for Army service which he spent first in Europe and later in the Far East. At the time of his discharge he was in charge of the Surgical Division of a General Hospital with the rank of Lieutenant Colonel.

In 1948, he returned to Guy's as an ex-service Registrar and in June, a month before the introduction of the National Health Service, he was appointed Assistant Surgeon to the Hospital. He also became a Clinical Assistant at St Marks Hospital and later Consultant Surgeon to Sevenoaks Hospital. Very soon afterwards he was appointed an Examiner in Surgery for the University of London and acted in that capacity for both General Surgery and Dentistry.

Noel Glover was a most able surgeon, and his judgment in a difficult situation was superb. His ability was recognised by the number of colleagues who consulted him on their own behalf or that of their families. He was kind and compassionate and had complete surgical integrity.We all enjoyed the privilege of working with Noel for almost thirty years. During that period, none of us can remember having a serious disagreement with him. He was a delightful colleague and never failed to show his gratitude for any help he received, however small its nature.

He was particularly interested in the surgery of the ductless glands and achieved a wide reputation in the treatment of hyperparathyroidism. He was the first surgeon at Guy's to carry out a porto-caval anastomosis. He also recognised the tremendous handicap varicose veins can be and the misery they can cause. His patience in operating upon them was unlimited. In consequence he became a leading authority on this disability.

Noel was never particularly interested in medical politics. Nevertheless he was prevailed upon to accept the Chairmanship of the Medical Committee of the Hospital and of the School Council for some three years before he retired in 1983. His wise counsel and common sense approach to any problem were of inestimable value to both.

He took a keen interest in sport, particularly cricket, and for some years was President of the Guy's Cricket Club. Also, for many years he undertook the thankless task of Convenor of the Biennial Dinner. He was a great collector of antiques, Persian carpets and paintings and was very knowledgeable about the latter.

In 1951 he married Jean. They had five children, two of whom, Joanna and Michael, graduated in medicine at Guy's. Sadly, Jean became ill and died in 1980 and shortly afterwards the tragic death of his eldest daughter, Joanna, on the threshold of a most promising career in anaesthetics, was a terrible blow. Although those who knew him well realised how deeply he was affected by these tragedies, with typical courage he did not allow his personal sorrow to influence his work in any way and he carried on with his surgical and administrative duties at the hospital until he reached normal retirement age in 1983.

Noel Glover was never one to seek the limelight, and was only well known within the circle in which he worked. However, within that circle, he exerted a tremendous influence and enjoyed the greatest possible respect from his colleagues both as a man and as a surgeon. He made a great contribution to the Hospital and School and will always be remembered by his many friends there as a true Guy's Man.

DMC, PJH, KSM

Surface Anatomy: The Anatomical Basis of Clinical Examination. John P S Lumley, Churchill Livingstone. 1990. Price £9.95.

Many preclinical students find that being asked to demonstrate the surface markings of deeper structures on a live model is the most daunting part of an anatomy *viva*. Their worries reflect not only the fact that living anatomy and surface anatomy rarely receive sufficient emphasis within courses in human anatomy, but also the absence of textbooks which cover this aspect of anatomy in adequate detail. The sub-title of Professor Lumley's new book neatly summarises its aims: to describe the visible and palpable anatomy that underlies the basis of clinical examination. The book is arranged in regions, covers all areas of male and female anatomy, and includes line drawings which indicate common sites for injection of local anaesthetics, accessing blood vessels and making incisions. There are over 200 colour photographs, many with superimposed numbered overlays. The accompanying text is clear, with an emphasis on clinical relevance. Inevitably, there are a few typographical errors, and the photographs of finger adduction and abduction have obviously been transposed at some stage during the final preparation of the manuscript. However, these are minor quibbles and in no way detract from the fact that this is an excellent book which all preclinical students (and their teachers) should read.

Susan Standring
Reader in Experimental Neurobiology

Lecture Notes on Immunology. Gordon Reeves & Ian Todd, Blackwell, Second edition, pp. 192, soft cover. Price £9.95

This is the second edition of a book covering both basic and clinical aspects of immunology within the confines of a small format 192 page paperback. It updates a 1987 first edition, and despite the appearance of two new chapters, it is no larger. The book aims to address both undergraduate and postgraduate students of the biological sciences, and particularly clinical, dental and veterinary medicine students. Approximately half of the book is devoted to basic immunology, the remainder is concerned with immunopathology and transplanation. This is obviously a lot of ground to cover, but the book does manage to remain coherent and readable. The text is supplemented by simple black and white figures, and there are a few generally up to date references at the end of each chapter.

The section dealing with basic immunology starts with an overview of the subject, and then deals with individual areas of immunity and the immune system in nine concise chapters. The material includes some recent advances in areas such as HLA structure, and lymphocyte receptors and their ligands. However, one criticism is that whilst the new chapter on cell interactions and cytokines offers a good general summary of this topic, there are some areas in which it is rather unhelpful to the uninitiated. For example, the legend to one figure uses both 'interleukin' (IL–4, IL–6) and 'factor' nomenclature (BCGF–I, BCGF–II) without an explanation of the relationship between them. A 1991 text should not add to any confusion acquired from the literature of the previous decade.

The coverage of immunopathology and transplantation is quite broad, although

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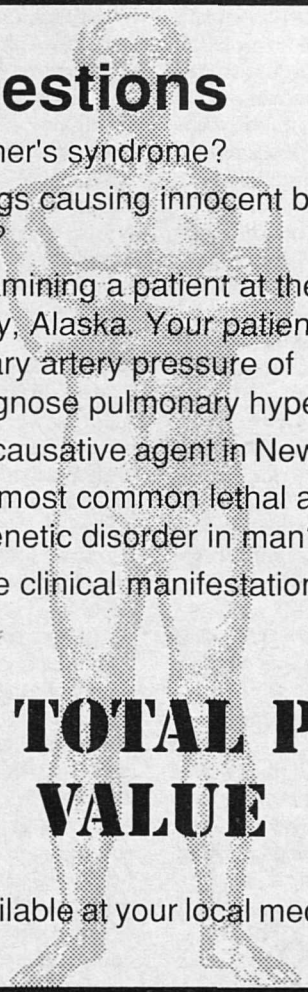

The Questions

1. Define Werner's syndrome?
2. Name 3 drugs causing innocent bystander haemolysis?
3. You are examining a patient at the summit of Mt. McKinley, Alaska. Your patient has a neopulmonary artery pressure of 21 mm Hg. Will you diagnose pulmonary hypertension?
4. What is the causative agent in New Guinea Lung?
5. What is the most common lethal autosomal dominant genetic disorder in man?
6. What are the clinical manifestations of CREST?

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not in any great depth. The new chapter on susceptibility to immunological disease includes the recent observations concerning the nature of the residue at position 57 of the HLA DQ antigen, and the occurence of type I diabetes. However, space is not found for other quite major areas of current research activity. There is no mention of the aberrant glycosylation of IgG of rheumatoid arthritis patients, nor is the use of LAK cells in immunotherapy included.

This book does cover more than the unassuming title of '*Lecture Notes*' might suggest. It is in effect an immunology primer plus a clinical immunology text compressed into one. The result is that the non-clinical immunologist is exposed to a reasonable array of the clinical aspects of their subject, whilst the clinician is presented with the bare necessities of basic immunology. In conclusion, this book is a worthwhile acquisition for both, as long as it is not the only immunology text on their shelves.

Paul Walker

Lecture Notes on History Taking and Examination. R Turner and R Blackwood. Blackwell. Price £8.95.

Those of us who have difficulties keeping up with the latest interleukin or the next generation cephalosporin are thankful that things change slowly in the field of history and examination. It is eight years since Turner and Blackwood's first edition of these *Lecture Notes*. The book is slim, less than 200 pages with lots of line diagrams and white space free of text on the pages. It is involved in a field which contains a number of competitors of various size and quality.

In common with most such books too little attention is given to the area of history taking and of communication with patients. Communication in difficult circumstances is not discussed.

A few old mistakes are wheeled out yet again, such as the 5g of desaturated haemoglobin for cyanosis. I was dubious about some of the information on reflexes and tone in the neurology section. Those of you who want to spot the deliberate mistake for yourselves should shut your eyes for one sentence. I spotted the upside down abdomen with the enlarged spleen on page 69 without too much trouble. Now open your eyes and read on.

Most chapters contain a number of helpful lists which summarise the main features of common disorders. Towards the end there are sections on certain investigations, rather brief to be of practical help except for the ECG chapter. There is a useful chapter on Assessment of Disability and Care of the Elderly. The section on problem orientated medical records suggests a sensible modified approach but it would be helpful to have some more practical advice in this area.

This is a competitive market but Turner and Blackwood's book is a useful addition. There will still be the need for a longer book explaining the terms, the methods of performing some of the tests and going in to more detail all round. This will be useful as a quick reference for students early in their career and it will be a handy addition to the bulging white coat pockets of medical students.

John Rees

An Introduction to Cardiovascular Physiology. J R Levick. Butterworth, First Edition. Price £14.95

Small monographs dealing with individual physiological systems have proved popular with students as supplements to the standard textbooks. The works of West on respiration, by Lote on the kidney and by Carpenter on the nervous system have been found particularly valuable by students. Until now there was no equivalent book on the Cardiovascular System which could be unreservedly recommended to students. This new book by Dr Rod Levick, Reader in Physiology at St George's Hospital Medical School, more than adequately plugs this gap.

With 266 pages the book may appear a little formidable, but the text has an easygoing style and contains numerous helpful illustrations. Many of them are standard drawings used in teaching cardiovascular physiology whilst others are original. Throughout the text I detect much which is in sympathy with the approach adopted by the teachers in the Sherrington School. The author has carried out some outstanding research on capillary fluid transport and his deep understanding of these problems has been incorporated into sections on the topic. The only weakness is the almost total failure to discuss the interaction of the cardiovascular system and the kidneys in the long term regulation of arterial blood pressure.

I thoroughly recommend this volume to both first and second year BMS students. They will find that a few hours spent with this book will considerably increase their knowledge and understanding of the cardiovascular system, which they will value well beyond their pre-clinical training.

F J Imms

Lecture Notes on Haematology—N C Hughes-Jones, S N Wickramasinghe. Blackwell, fifth edition, soft cover. Price £10.95.

This book is one of a plethora of 'handbooks' in haematology currently available on the market which are aimed at medical students and housemen. The emphasis of the work reflects the area of interest of the authors but most topics are covered (although some better than others). With the explosion of knowledge in molecular biology and cytogenetics there is a need for medical students to obtain a core knowledge in this area which is noticeably missing from this book. This is, I think, a major omission. The section on haemostasis also omits to discuss the rapidly expanding area of prothrombosis with the exception of two paragraphs on antithrombin III and proteins C and S.

I think the objectives in learning at the end of each chapter will be a valuable aid to those taking final examinations. Although the figures and tables are comprehensive, the authors have made an effort to explain underlying principles thus avoiding the urge to learn by rote and in the main they have been successful. I think this is a useful book for undergraduates but on its own it is inadequate to answer all the areas now expected at this stage of what is a continuous learning curve.

Dr S A Schey

All Good News

This month has been quite a busy one for the Union. The President has collected the minibus from darkest Richmond and it is now available for hire (please ring Helen for bookings).

Recently the Union has focussed its attention on the security arrangements for Hops and also on the piece of paper issued to graduates conferring life membership. In the near future a plastic 'credit card-type' membership card will be issued. Also, by issuing them in advance to current students they will be spared the weekly ritual of unclipping their blue identity badges from their white coats.

Self-policing is now in operation in collaboration with Canon Security, so any budding vigilantes amongst the ranks should contact the Union—it will help your pocket as well as the Union's. To help with the problems on Friday nights we have issued 100 affiliate membership cards to nurses and therapists, and anyone else in pursuit of one (a card that is) should enclose a crisp £5 note or cheque (to UMDS) to Dr T Gibson, Shepherd's House, Guy's.

The clubs now run an efficient cloakroom to help keep your coats safe (no valuables, please). Finally may I remind you not to sign in anyone that you do not know and try to get here before 'pumpkin time'—that gives seven hours drinking.

In the bar, the work of Paul Frisby and his minion Andy Klein are showing results in the form of the lunchtime Cafe-Bar, open from 10.30 am to 2.30 pm serving a range of tantalising dishes ranging from toasties to mushroom and nut fettuchini.

Elections for posts for the coming academic year are due to be held in May, so if you would like to give some time and direct your energy towards improving facilities and social events for fellow students, then get in touch and start your campaign. I wish you all luck.

James Lewis
Vice-President

Charities Week

In your last issue we mentioned that Guy's and St. Thomas were holding their first ever combined charities week. Since then we have made much progress and I am now able to present the provisional rag timetable for evening events:

Wed 24 April: Pre-Rag Week warm up—Carribean evening at Guy's

Thur 25 April: Karioke evening at St. Thomas'.

Fri 26 April: Fifties night and pub crawl to and from Guy's and St. Thomas'.

Mon 29 April: Rocky Horror film show with Hop at St. Thomas's.

Tue 30 April: Toga party, slave auction, film and Hop at Guy's.

Wed 1 May: Afternoon at Honor Oak Park, evening BBQ and games

Thur 2 May: Comedy evening and Beer Promotion at St. Thomas'.

Fri 3 May: Gangsters and Dolls Rag Ball at St. Thomas'.

All events are to be held in the bar of the appropriate campus at about 7.00 pm. In addition we have all the usual hit squads and many more 'surprises'.

This year we aim to support the 'children of Guys and St Thomas' with money going to:

Evelina Childrens Hospital Fund
Evelina Children Heart Fund
Evelina Children Family Trust
Evelina Children's Heart Organization
Special Care Baby Unit Appeal Fund
St Thomas' Baby Fund.

In addition, we hope to support many other national/international charities. We do hope that attendance at our events will be high on **every** night of the week but that depends on support from the entire staff of both hospitals. Remember 'Rag Week' isn't just for the medical students—whoever you are, you're welcome to come along. We are counting on you to make this the most enjoyable and successful charities week ever.

Dan Ellis
Charities week President

'We didn't know they cared'

—Ever found yourself with a splitting headache just before a wardround and not a paracetomol in sight?
—Ever suddenly realised that you're off to India next month and your last vaccination was on a sugar lump at school?
—Ever felt you couldn't cope any longer but didn't know where to turn?

Concern yourself no more, for help is at hand. October 1 saw the birth of the new Occupational Health Service for UMDS students.

It's based primarily on the floor 12 of the North wing at St Thomas's (in extremely pleasant surroundings) and is open from 7.30 am to 5 pm, Monday to Friday.

For those unfamiliar with the concept of occupational health, its not supposed to replace the GP. What it can provide is on the spot advice and treatment for any health problems troubling us during working hours, and that includes everything from minor ailments to immunisations for work and for our electives. It also looks after our mental health needs, offering confidential support and advice both on floor 12 and through the new student counsellor in Riddell House.

Jane Hockley, the Occupational Health Nursing Sister, is steadily working her way through the task of seeing each one of us during the next few months. Her aim is to introduce us to the service and find out if we've any particular health needs that she can help us with. To help her do this, we'll be asked to fill out a general health form, which will then be kept on file in the department. One thing Jane is keen to emphasise is the confidential aspect of the service. The records never leave the department and any decision to involve members of staff outside occupational health rest entirely with us.

I asked Jane why we need to register with a GP as well. She explained that while the occupational health department does have its own consultant physician and registrar, their role is to give advice on work related problems such as long standing back injuries or stress-induced illnesses. They don't only look after the students' occupational health. However, Jane does suggest that if our GP recommends referral to a specialist, we should bring our referral letter to her department and they will ensure prompt action is taken. She also suggests that the occupational health doctors can offer additional help and support during chronic illnesses, such as glandular fever.

And future plans? Well that, in part, rests with us. Jane is keen for as much feedback as possible to help improve the service.

They're already appointed a part time senior physician whose sole responsibility will be to UMDS students. He's due to join the team in March and will replace the consultant and registrar who currently help out on the student side.

Finally, the appointment system will be clarified as soon as the initial screening service is completed. At the moment you may be seen immediately if it's not busy or may have to make an appointment or join the queue if it is.

But the main message was 'we're here to help you'. And in a profession where the all too frequent message is 'physician heal thyself', it's nice to know that UMDS recognises that we might need a little help along the way.

Summary of Main Services Offered

- 'Self medication' for minor ailments (paracetamols, cough linctus, plasters, E45 cream, antacids etc)
- Treatment of minor injuries and wound dressings.
- Free Immunisations (except yellow fever which costs £10) for work purposes and electives. (This includes assessment of Hep. B. and rubella status.)
- Phlebotomy service
- Pregnancy Testing Service & Counselling.
- Medical Opinions (from Consultant or registrar)
- Sickroom with bed(s) for rest and recovery (eg if you develop a migraine).
- Walk-in crisis counselling and support (ranging from a private room which you can escape to, to trained staff if you need to talk).
- Student Counsellor based at Riddell House who can be contracted directly, without any referral.
- Management of referral from GPs to specialist.
- Health education advice on everything.
- Occupational related advice eg on needlestick injuries (NB you should always report these and bring the ward incident book with you to Occupational Health).
- Liaison with Occupational Health departments at Guy's and peripheral hospitals. (these hospitals only offer a limited service but should at the very least deal with needlestick injuries. If you encounter any problems, let Jane know).
- Teaching sessions on paramedical topics such as lifting patients to avoid back injuries; first aid (to be arranged with Jane on a group basis).
- Environmental surveys (if you come across something you'd like investigating in the hospital eg lighting; floor surfaces; noise—let Jane know.)

Contacts

Jane Hockley, Occupational Health Dept, Floor 12, North Wing, St Thomas' (ext 2302)

Paul Parli and Diana Boss, UMDS Student Counsellors, Floor 1, Riddell House, St Thomas' (ext 3141).

Should Dentists Assume the Title 'Dr'

Speakers:

for: Douglas Pike, Anthony Morton

against: Dick Haskell, Bloggy Howarth

This was a most entertaining evening. We were very fortunate to have Douglas Pike propose the motion. He has been in the vanguard of those compaigning for dentists to be able to use the title Doctor. He eloquently introduced the subject, pointing out that the United Kingdom is now the only country in the world in which dentists are not afforded the courtesy title. Now that all EEC dentists are able to practise freely in the UK many feel that British dentists may be disadvantaged, as in the eyes of the public the foreign dentists appear to be better qualified. Douglas Pike also stresssed that using the title would give the dentist a certain mark of distinction which was deserved.

Dick Haskell led those against; well known to most of us of course he is unusual among dentists in that not only is he medically qualified but he also has an MRCP. He traced the historical background to the present title position in the UK. Originally only the Physicians were 'qualified'. They were usually classically educated and theorised, but did not necessarily touch the patients. If a practical/surgical procedure was required, the barber surgeon was summoned, who operated under the direction of the physician. When surgery advanced as a speciality in the 1850's, surgeons now qualified, gained great delight in reverting to the title 'Mr', a title still feverishly protected. Dental Surgeons by the very nature were part of surgery and not medicine and were therefore 'Mr'. Elsewhere this historial precedent is absent and dentists use the title 'Dr'. The speaker maintained that a title was irrelevant. The respect of both your patients and peers was the important point.

It was difficult to follow such a well argued case, but Anthony Morton, a general practitioner whose son is an undergraduate at Guy's, did a fine job. He reiterated the implications of free EEC movement and obviously felt strongly that UK dentists should not be perceived as holding qualifications of inferior status to their EEC counterparts. We were told that it was essential that dentists retain the rights to administer general anaesthetics and sedation, rather than lose these important skills. Anthony Morton stressed how much the dental course, now 5 years in duration, had changed and the title 'Dr' would recognize the transition in skills away from surgery.

Bloggy Howarth concluded the argument against with a passionate and very personal approach as only he could. He lives in a family of doctors including father, uncle, brother, brother-in-law and son and we were told that he had a place to do medicine at Charing Cross Hospital in 1950, but he was launched into his National Service. He has never regretted chosing dentistry as his profession or using the title 'Mr' for his practising life and has never felt he needed a 'handle' with his name. We were reminded that vets are called 'Dr' everywhere except the UK and British vets seem happy enough and they take longer to qualify than anyone.

'Calling yourself Dr would not improve your skills or get you more patients. We were the important ones not our titles.'

A lively discussion then followed and we were able to hear the views of many of our staff and students—views that were often strongly felt. It was very interesting

to see that of those who joined in the discussion, three who were PhD qualified were in favour of dentists using the title. We were informed that the British Dental Association was already addressing all dentists with the title 'Dr' and for the first time the President of the General Dental Council was in favour of a change to the Dentists Act, allowing the use of the courtesy title. It would appear that it is only a matter of when rather than if.

The vote, eagerly awaited, was 37 for, 17 against, which in the rather subjective view of the author seemed to be at variance with the strength of the arguments, but there again he voted against.

Lyndon Cabot

Where Do You Live?

Our Acting Director of Nursing Services has circulated a big 'thank you' to all nursing staff who maintained a normal service during the recent 'trying times'. We were all amazed at the seasonal arrival of snow in February, followed closely by the IRA bombs; both events which made travelling to work slow and difficult.

However I recall a writer whose name escapes me, probably a sociologist or someone else of similar ill-repute—judged by today's standards, once suggesting that professionals such as doctors, nurses, teachers and social workers should live within the same *environs* as those whom they serve. Perhaps a reader can recall who this writer was—I should like to know? If his advice had been followed in the hospital fewer staff would have found it difficult to get to work: they would probably have been able to walk!

Moreover, the point is not just that living near to one's work makes the journey simpler, but living close at hand makes for greater awareness of the problems faced by patients or clients. In the past most nurses 'lived in'; at Guy's sisters at one time actually resided in a room attached to their ward. One could hardly be closer. I doubt many nurses would accept this now. Nevertheless most nurses still live close enough, and indeed nearly all managed to reach the hospital regardless of inclement or explosive conditions. Does the same apply to all others who join us in patient care? The decline in nurses 'living in' has been enhanced by the lack of available accommodation. But knowing the circumstances of living in an inner city area of urban decay surely makes for greater empathy with patients compared with living in the lush pastures of outer suburbia?

It is at this point of closeness to the service provided that we can see whether the government's reforms are damaging the NHS. This was the subject during a recent programme in the 'Radio 4 Debate' series. The vote concluded support for the case, put forward *inter alia* by the Emeritus Professor of Human Metabolism at Guy's, that these reforms are damaging, and most significantly in the inner city

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areas. The hospital is just embarking on Trust status with diminishing funding, which even our Chief Executive admits will not mean the disappeareance of all our problems. Nurses jobs are vanishing, wards closing and even that high profile spot in preventive medicine, AIDS services, suffering during this period of reform.

Nurses seem to have little power to prevent all this, despite, as I have emphasized, their local base. The place of residence and social geographic background are all to the fore in the new training scheme for nurses—PK2—otherwise known as Project 2000. Understanding this aspect of patient care, health promotion and disease prevention, are primary parts of the course. This means looking at the outside community before starting bedside nursing. It will take a considerable time before those trained with this emphasis succeed those of us still more aware of treatment than prophylaxsis in disease.

I realize that some of this may smack too much of a sociological approach, which may be regarded as too politically oriented and unacceptable for folk who look in other directions fortheir explanations of faults in the NHS. But if the service nurses provide is to be relevant to the locality we work for, it is an unavoidable consideration. Living close at hand, knowing the grotty conditions and lack of facilities, is an important factor. Commuting long distances to work has become popular and to some extent easier during the late part of the twentieth century, but as the writer I mentioned at the outset knew, removes those who live in private affluence from the public squalor of their clients and patients.

Denis Cobell

PHYSIOTHERAPY NOTES

Trans-Atlantic Crossing

A handful of Teachers and one clinician left Shepherd's House and picked their way through the building site to London Bridge station, bound for the Underground to take them across the River to the school of Physiotherapy at the Middlesex Hospital, there to attend a meeting of the Association of Teachers of the Chartered Society of Physiotherapy. (ATCSP) The Thames has been said to be (in terms Ecclesiastical) as wide as the Atlantic Ocean. Is this the case regarding the Teaching of Physiotherapy? We were about to find out. The first problem of how to approach the target was solved by agreement to catch the first train which presented itself. It happened to be the southbound train and so Kennington was the station of change *en route* to Goodge Street.

The small party arrived in good time for the 2 o'clock start. Having not had lunch, the sight of coffee and sandwiches was very welcome. Unfortunately, they remained under their cling-film in a tantalising manner and after general chatter the delegates were ushered to their seats to commence the session.

'The 'session' turned out to be a General Meeting of the London Branch of the

ATCSP, at which the hungry clinician felt like a fish out of water on the wrong bank of the river unable to participate in the machinations of this association, memories of student days in this august establishment flooded back. Prior to the building of the Arthur Stanley House, the Physiotherapy School was a series of huts between the Out-Patient Department and what is now the Medical School. The first sign of the building of the Medical School was the demolition of the squash court and the Physiotherapy gym, such are shades of the Guy's new building's enabling works—who would have dreamed of such a connection some 30 years apart? Is it in such things that rivers are forded or that two Teaching Hospitals are compared?

The noise was a problem. It wasn't there in the old days—tucked away behind outpatients–but now the traffic on Tottenham Street drowns even the most illustrious speaker. How difficult it must be to learn the concepts of Physiotherapy in these rooms.

Thankfully, the meeting came to an end and a cup of coffee was offered. Unfortunately the charge to the coffee table was quashed and order called. It was not yet the time for refreshment.

The second part of the afternoon was a great improvement on the first and the purpose of the visit was revealed. More clinicians arrived and the programme was announced. We were gathered to consider the differernt forms of Physiotherapy courses in London. Four courses were presented very professionally.—One 'old' course in a University and one 'new' course in a University; One 'old' course in a Polytechnic and one 'new' course in a Polytechnic—Interestingly the two 'old' courses were north of the River and the two 'new' courses were those starting-out in the South East Thames Region. As we all know by now, the Guy's school and St Thomas' School close at the end of the 1991/2 academic year and SETRHA will be supporting the 'University' based course at King's and the 'Polytechnic' based course at Brighton (Eastbourne Campus).

After the presentations the official break for refreshments was announced and thankfully sustenance was at last at hand. This, however, was not the end. The final session took another shape—that of a question/answer/discussion forum. Fortunately we did not have to 'break into small groups'. A member of staff from each school was on the panel and at this stage Guy's was represented. As the discussion progressed it became obvious to me that the Guy's course comprised most of the ideals that were being chased by the other establishments.

What a shame that it will be unable to continue.

Diana Innocenti

Rugby Club

Hospitals' Cup Campaign
Guy's v Charing Cross and Westminster. Won 13–10

This season Guy's entered the UH Cup competition with considerably more commitment and optimism than in recent years. A young squad began training in the new year and every place in the team was available for cup competitions. The pack, fielding light but fit and mobile forwards, complemented the backs led by the Docker-Davies half-back partnership.

In the first match versus Charing Cross and Westminster, the hard work and fitness of Lewis and Ivil earned them places in the side. Guy's began rather hesitantly and Charing Cross used their size and weight advantage to drive towards the Guy's line. Their efforts were finally rewarded with a penalty goal, which gave them the lead.

At this point Guy's began to assert themselves, dominating second phase play through Cunnington and Llewllyn, and Davis levelled the score with a successful penalty kick. This set the pattern for the rest of the half, with Guy's gaining the lead through another Davis penalty, and then a well-taken try scored by Patrick Beardmore.

Guy's made the interval with the lead but faced a fierce Charing Cross in the second half. Despite tenacious defensive work by Guy's, Charing Cross clawed their way back to level the scores, with ten minutes remaining. Both teams then poured forward in an orgy of attacking rugby but the Guy's defence was impregnable and Charing Cross were relentlessly forced back into their own half. With five minutes remaining, Neil Davis struck a magnificent penalty goal from 45 yards to give Guy's the lead once again; resolute defence then sealed a well-earned victory for Guy's and a place in the semi-finals against St Mary's.

Incidentally, Guy's also secured a victory on the terraces with Charing Cross suffering many 'egg casualties' during the course of the match. The Rugby Club does not condone such behaviour.

Guy's v Mary's
Old Deer Park. Lost 15–0.

Yet again, Guy's were drawn against Mary's, who are undoubtedly the strongest team in the UH Cup. Preparation for the semi-final match was hampered by the weather conditions, but players maintained their fitness by using the Tower and the tunnels at Guy's. The spirit and atmosphere built up during the week, and on the day the famous 'churn' was produced in anticipation of a great game.

The match at Old Deer Park began in typical cup style with frantic tackling and spoiling tactics, and Guy's, with the wind in their favour, threatened the Mary's line a number of times—just failing to convert pressure into points. Neil Davies narrowly missed a good drop goal attempt and also missed a long penalty goal, in contrast to the match against Charing Cross. We lost Roy early on after a stray Mary's boot caused a gash in his head (requiring 40 stitches). Eventually Mary's weight, size and good driving tactics took their back row over the Guy's line for the only score of the first half. Guys could have replied to this score after a fine break down the right hand side by Breeze, supported by Docker, only for his pass to be dropped by Pat Davis. This left the first half score at 4–0 to Mary's.

In the second half, with the wind in their favour, and guaranteed possession from the lineouts, Mary's dominated the

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game, despite valiant Guy's tackling. The pressure was rewarded with a try worked from a rolling maul involving Ellery, their Richmond prop, and their other immense forwards.

Despite the match beginning to slip away the Guy's team held together and had a considerable period of pressure driving towards the Mary's line on the right hand side only for a scoring pass to be deliberately knocked on by a member of the opposition.

Mary's kicked us back into our own half for another period of territorial dominance where again they eventually went over for a try. This basically ended the game at 15–0 and the full time whistle blew only minutes later. The score did not represent the closeness of the contest, even though Mary's were the stronger team. I feel that had Guy's taken their obvious scoring chances and gained momentum and a pattern, it may have been a different outcome.

As in the Charing Cross game, the support was tremendous and in the near future I'm confident that we will beat St Mary's regardless of which round we meet them.

Guy's 1st XV v Streatham & Croydon 1st XV
23 March 1991 draw 15–15

A depleted Guy's team (due to injuries in the Cup travesty in midweek) began strongly against a team two divisions higher than themselves. The forwards immediately began to dominate the opposition and present the backline with excellent ball and time to use it—which they did with a combination of intelligent kicking by Neil Davies and strong running by the centres Steve Lewis and Jeremy Worth.

As a matter of course, when under sustained pressure the Streatham forwards began to play offside and Neil Davies—with the help of the wind—converted one of two attempted penalty kicks. Then a surperb run by Richard Breeze and a perfectly timed pass by Andy Hall put Steve Lewis in for a try—as the fitness of the backs began to show.

The back row forwards, especially Jeff Taylor and our own colossus Bill Murphy, exerted extreme pressure on the oppositions back line and won a five yard scrum from where Jamie Combes went blind and managed to squeeze a pass away to Jen Bootroid who in turn put Richard Breeze in for the try in the corner—which was excellently converted.

The second half was dominated by the wind as Streatham scored a try and kicked 2 penalties and a drop goal—which settled the game as a draw. Guys should easily have won after leading 15–0 at half-time.

Guy's 3rd XV v Old Reigatians
HOP March 9. Lost 18–21

On both pitches there were stirring events. The first fifteen won 16–15 in a cliff hanger, a score which should ensure their place in the league. On the other pitch the issue was more mundane but not without passion.

In characteristic fashion, the hospital side generously started with 14 players. It concluded with 13. The opposition were not that marvellous but the presence of two powerful runners in their side meant that every break introduced the possibility of an overlap. Guys actually took the lead when Tim Lloyd kicked a penalty from the 10 metre line. Unfortunately the opposition also had a kicker of merit, within 20 minutes, the score stood at two penalties to Old Reigatians and two to Guys. In the interim the old boys also scored two tries, both converted. At half time the

score was 9–18. It seemed possible that Guys would lose heavily.

In the second half, the home side tackled with more determination, kicked less and ran at and through their opponents with increasing confidence. There was some fine running and handling by the back row and Willings was especially prominent in attack. Most of the backs had plenty to do. Bailey showed some aggressive running, Russel tackled well, Quick used verve rather than pace, Farland linked well and defended with spirit and Underwood remained cool, joining the line when he could.

The revival started amongst the forwards. Frustrated and angry they set about the opposing pack, pushing them off the ball and contesting possession with more vigour. Reigatians added a penalty to their final score after some careless footwork by one of the Guy's forwards, Gibson scored a try which Lloyd converted. One more penalty was all that could be achieved before the whistle. It was a memorable performance.

Team: C Howell, T Gibson, K Smith, P Davis, M Popplewell, M Willings, J Conchie, J Hawker(Capt) T Lloyd, S Bailey, S Russel, D Quick, T Farland, K Underwood.

Football Club

UH Cup Final

It's that time of year again, when Guy's sports clubs are vying for cup success and once again it's the football club who keep the flag flying high for Guy's.

This year it was the turn of the 2nd XI, who have now succeeded in capturing the Hospitals' Cup for an unprecedented third time in four years.

On this occasion, King's College Hospital were sent as lambs to the slaughter.

After a brief pitch inspection it was down to business and at precisely 1 o'clock on Saturday 2 March the game kicked off.

The match began at a ferocious pace with King's settling the better of the two sides and had the audacity to take the lead after 15 minutes.

However, Guys showed their steel and fought back, and after several near misses finally cracked their defence. Julian Page took a quick throw on the edge of their penalty area, the ball was flicked on beautifully (even if I do say so) by myself and Darren Gillet hit a superb volley past the desperate, sprawling dive of the King's keeper to make the score 1–1. The scoreline remained unchanged by half-time and the lads went off the field to enjoy a hard-earned half-time cuppa.

The second half was a close affair with honours shared evenly for the most part. Pat Dixon (our keeper) made a string of good saves, Darren Gillet dominated the midfield and Andy Hamilton, together with Neville Naterwalla, were towers of strength at the back. Then, with 9 minutes remaining, Jon Boden was spectacularly fouled on the edge of their box. Raj Sajanhar stepped up and curled a free-kick with such aplomb that he was being hailed as the new Gazza.

In the last 9 minutes, John Staffurth was forced to clear off the line on two occasions and we were relieved to hear the final whistle, upon which Tim Murray launched a well organised one-man pitch invasion—thanks Tim.

Team: P Dixon; J Staffurth; A Hamilton; N Naterwalla; R Gupta; J Page; R Sajanhar; D Gillet; S Kelley; J Boden; M McLoughlin **subs.** T McHugh, D Schofield.

Sat Kelley
2nd XI Captain

Boat Club

UH Head of The River
Mens 1st VIII Report

Since Christmas the Guy's and St Thomas's 1st crews had been reduced in strength by exam commitments and so had decided to train together, concentrating their rowing in small boats. The old rivalry between the hospitals and the natural competiveness of the oarsmen was evident on many occasions when the squad trained side by side in IV's, the crews evenly matched. These outings promised great things when the crews combined to form an VIII. Its first test was the United Hospital's Head of the River Race.

This year the race was held on Wednesday 27 February and divided into two separate events. The 1st crews rowed at midday from Hammersmith to Mortlake, and later in the afternoon the 2nd crews competed over the same distance but in the other direction. Both races, of course, with the tide.

The combined crew, rowing under the name of Guy's to avoid confusion with race officials, was third in the starting order behind St Barts, with the London Head. In true UH fashion the start was complete chaos but most crews got away smoothly if not in the correct order. Weir, stroking for Guy's, set a rate of 32 and almost immediately began closing on Barts. Within a few minutes the crews were level, but good steering from Fozouui, cox of the Guy's boat, had secured her crew the advantage of the stream and they began to pull away. Now Guy's were only two lengths behind the leading boat. The bend was to London's favour as the crews approached Chiswick steps but Guy's put in a push and closed to within a length. The London's challenge then appeared to evaporate and the chasing boat flew past.

With both Barts and the London destroyed, Weir took the rate down 2 pips and Guy's found a steady rhythm which was maintained throughout the course of the race. At Mortlake, which was reached in 10.02 minutes, Guy's were over 5 lengths clear of the London and over 20 seconds faster than their nearest rivals.

This was an impressive row and the combined crew from Guy's and St Thomas's Boat Clubs had passed their first test with flying colours.

Crew: Bow John Crossman, 2 John Robin, 3 Andy Armitage, 4 Andy Williams, 5 Matt Smith, 6 Justin Rodgers, 7 Matt Gray, Stroke Rob Weir, Cox Phetna Fozouui.

Matt Smith

UH Head
Mens 2nd VIII report

The United Hospitals Head of the River race provided the first test of the season for the newly formed 2nd VIII keen to pick up some pots after a barren Autumn Term. Conditions at the start were far from ideal with a strong wind, a fast current and a start right outside the boathouse which left little opportunity for a warm-up. Appalling stewarding by the race Marshal ended up with Guy's wiping out the Lond Hospital 2nds on the middle pillar of Chiswick Bridge, but Guy's quickly recovered to make a good start and settle into a comfortable rhythm.

Having eased their way past a women's crew at the half way stage, the crew—with stroke fighting a desire to be sick over the side of the boat—increased the rating to chase a Marys' crew who looked easy prey on the inside of the bend. A tough struggle followed, but excellent coxing enabled Guys to overtake just before Hammersmith Bridge, and finish the race in 12.46 minutes. After a complaint from the London Hospital about the start was not upheld, Guys were anounced winners by 4 seconds over University College and collected their first pots of the season. Jubilation at the success was tempered only slightly when it was pointed out that the womens 1st VIII had rowed the same distance almost 30 seconds slower earlier that day. Encouraged by this victory, the 2nd VIII look forward to the rest of the season.

Crew. Bow Richard Simons, 2 Ash Mosahebi-Mohammedi, 3 Andrew Hopkirk, 4 Neil Galletty, 5 Simon Manara, 6 Alex Cash, 7 Martin Seccombe, Stoke Guy McLellan, Cox Lara Churchill.

Martin Secombe

Reading Head of the River Race

The Head Races are long distance races, originally designed as warming up races for the Summer Season Regattas. In recent years, however, they have gained in popularity and there are quite a number of races organised between late January and March, culminating in the World famous Tideway Head of the River Race, in which 420 crews race over the Boat Race course from Chiswick Bridge to Putney. Reading is one of the earlier and at 4,250 m is one of the shorter Head courses. This year Guy's sent 2 mens crews and a ladies crew, all eager to add to the clubs previous wins at Reading.

Both the mens crews were slightly late in reaching the race start and so were given a Grandstand view of the Open and Senior I crews starting.

The first men's crew set off at 30 and settled down to 26 Strokes/min, holding a considerably more experienced crew from Southampton University. The crew managed to hold on to this crew after being overtaken and eventually finished in 17.02 minutes, 5th in their class. Reading was the first Head for many of the members of the Guy's Freshman crew. However this did not stop them from enjoying the race, and eventually finishing in a time of 19.05 minutes.

Martin Creedon	cox	Lara Churchill
Nick Spiker	stroke	John Crossman
Charlie Sherwin	7	Clive Lewis
Neil Hamoon	6	Neil Galletty
Steve Lull	5	Alex Cash
Richard Olding	4	Bobby Kelly
Arif	3	Martin Seccombe
John-Paul Carpenter	2	Richard Simons
Tom Downes	Bow	Maneth Patel

John Crossman

Ladies' UH Head Report

Both crews entered for the head were 'scratch' crews, which meant it was the first time they had rowed together. The first VIII had a good row despite the chaotic organisation at the start. We started at a good high rating and steady rhythm, one and one half lengths down on Barts., but we steadily gained on them until one of our crew caught a crab—disaster! Even so, we only lost to Barts by 14 seconds; we finished 3rd with a time of 12.17 minutes.

The second VIII were rowing in the afternoon so they had the unfortunate task of rowing from Hammersmith after the race. But spirits were high when they arrived back exhausted and bedraggled, after a good race. They won the Novice Shield by one minute, with a time of 15.13 minutes. Well done!

Crews: 1st VIII Str: D Bessey, C Burt, E Gibson, M Roberts, L Orr, C Francis, E Parkinson, L Churchill, Cox: A Klein.
2nd VIII Str: C Carey, K Zeiderman, C Francis, M Lear, S Haque, C Kelleher, F Abbas, V Goodall, Cox: A Klein.

Ladies' Reading Head Report

Despite all odds we managed to get all 3 crews on the start in time. There was chaos as everyone rushed to put the parts together and rig them before our time was up. Caroline and I stood in the drizzle and cheered on the ladies crews—they were looking good from what we could see, but the photo tells a different story! They made a fabulous time 20.01 minutes, coming third out of 8 crews and moving up from 92nd to 86th position; a fantastic achievement for such a hard head-race.

Congratulations to: C Carey, K Zeiderman, C Francis, M Roberts, F Abbas, S Mayes, E Parkinson, C Kelleher, Cox: A Klein.

Diane Bessey
(Ladies Captain)

UL Head of the River

Following the recent success at the UH Head, Guys entered three crews: two mens VIII's (the 1st VIII being a combined Guys and Thomas' crew) and one ladies VIII.

On a day when both strong wind and choppy water made rowing difficult, the composite crew did not row to its full potential; but after finding a steady rhythm the crew stroked the boat home in a time of 14.24 minutes. Aching limbs were rewarded with victory in the senior first division, making them the fastest hospital crew.

The mens 2nd VIII approached the race in the customary relaxed style. After rigorous crew selection the final line up included a rare balance of quality oarsmen and sheer brute force. Rowing in the customary '4 on each side configuration' the crew had an air of breezy confidence about them as they made their way up to the start.

During the race the crew galloped away from all the other opposition in the Novice Division and notched up another win for Guys in a time of 15.17 minutes, over 30 seconds from the next crew. This makes it 3 years in succession that Guys have won the Novice Division in this event, emphasising the clubs strength in depth.

The ladies 1st VIII were again forced to row in the Ladies Open Division. However the four freshers in the crew showed that although they have only been rowing for two terms they are by no means novices.

Throughout the race the crew rowed crisply and succeeded in holding off a mens crew for the last 700 m. They finished in a time of 17.10 minutes, resulting in a creditable third position in the Open Division.

All in all, it was a successful day for the club with the three crews entered winning two divisions.

Crews:

Mens 1st VIII: Bow J Crossman (Guy's), 2 J Robin (Guy's), 3 A Armitage (STM), 4 S Pryte (Guy's), 5 M Smith (Guy's), 6 J Rogers (STM), 7 M Gray (STM), 8 R Weir (STM), cox P Fozouui (Guy's).

Mens 2nd VIII: Bow A St Inkhammer, 2 R Deicher, 3 S Hodges, 4 R Sole, 5 S Manara, 6 A Mosahebi-Mohammedi, 7 B Kelly, 8 A Cash, cox L Churchill.

Ladies 1st VIII: Bow A Kife, 2 J Kennedy, 3 E Gibson, 4 S Blade, 5 S Mays, 6 L Orr, 7 C Burt, 8 D Bessey, cox A Klein.

Steven Pryke

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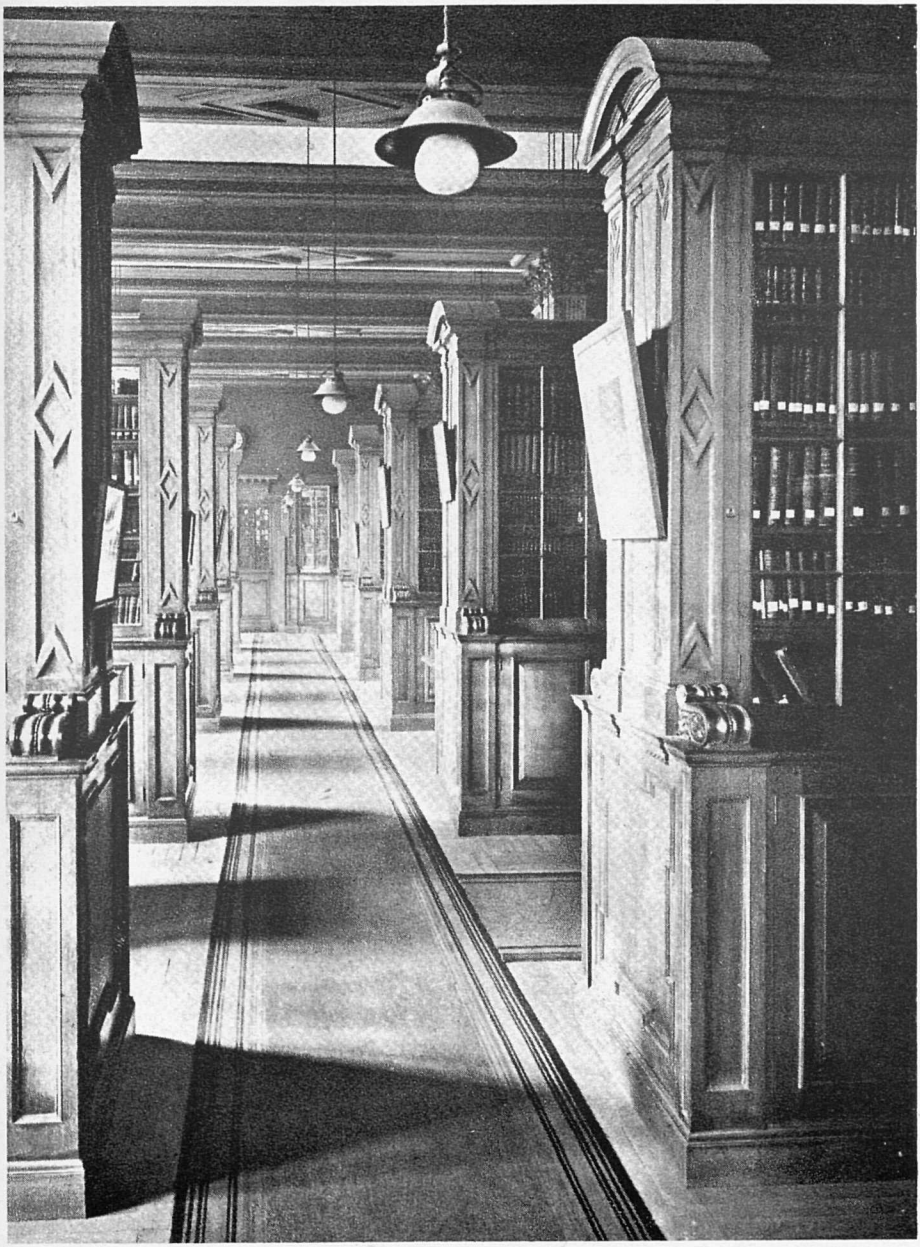

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Submitted by Mr S Pearce.

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Guy's Gazette

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Volume 105 Number 2412 May 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

It has been an inauspicious start for the new Guy's and Lewisham Hospitals Trust. Early reports of a woman in southern England who was denied a sterilisation because her health authority did not have a contract with the Trust, were followed by news of up to six hundred redundancies.

The job losses are part of a package of measures designed to reduce expenditure by more than £10m. The cuts are required because the hospitals have been running at a loss for some time, and have accrued a considerable deficit. These economies would, at least in part, have been necessary irrespective of whether the hospitals were self-governing or under district-control. Perhaps the only consequence of being self-governing is that the initiatives have been set into action at the beginning of the year, rather than as hurried, poorly planned cost-cutting at the year's end. It must be remembered however that market economies are ruthless, and that internal markets are no exception.

Each unit has been asked to undertake a critical self-examination to identify areas of inefficiency, and the results of this will be known by about the time you are reading this Passim. On the basis of these findings, the management will determine which areas are to be cut. They have made public assurances that these cuts will not impair the provision of health care (although their private assessment is apparently very different).

Efficiency and value-for-money spring not only from job cuts, but also from high morale and incentives for the remaining staff, all of which is dependent on good management. The Trust certainly has plenty of managers, in fact it is probably the only burgeoning department in the hospital, and much now depends on them. If, in association with clinicians, they can identify problematic areas and then formulate realistic, effective solutions then the Trust will flourish, to everyone's benefit (except perhaps another London teaching hospital).

It is time for the managers to start earning their money.

Mr Alan Yates

Dear Sir,

May I please add some memories of Alan Yates to 'JED's' tribute last month.

Parents and children will I am sure remember Alan for his meticulous and painstaking work. He was careful to make certain that parents fully understood what they needed to know, and in a language they understood. If the worst happened, and it did very, very occasionally, his own personal depth of sympathy was clearly conveyed and recognised by the parents, an event which I experienced with our shared patients on several occasions.

Alan Yates will be sadly missed.

Yours faithfully,

MICHAEL JOSEPH
9 Ham Street
Ham Common
Surrey

The Ripper is Savaged

Dear Sir,

Congratulations on your return to the A5 format. It is good to have the familiar *Gazette* back again.

It is however sad to see in your first issue the uncritical reproduction of a television broadcast on the true identity of Jack the Ripper. While most of us have long accepted that Sir William Gull never had a case to answer, the case made against Kosminsky was equally lacking in factual support and owed its existence to some hand written margin notes in a book, both the notes and the book written by people who had publicly failed to solve the crime.

Your report comments on the failure of an eye witness publicly to denounce the murderer, explaining it on his reluctance to stimulate anti-semitism. It also implies that Scotland Yard had the same concern and therefore failed also to publicise the solution of the crime. It would appear that Mr Schwartz and the Scotland Yard of the nineteenth century were more sensitive to this issue than our contemporaries.

Your report states unequivocally that Kosminsky was the killer on the basis of anonymous notes and with the apparent belief that because it was said on television it must be true. The inconsistencies in your own report, where you suggest on one page that a total lack of surgical anatomical knowledge clears Sir William and on the next that Kosminsky's history as a Barber Surgeon might explain how he came into possession of the murder weapon, do not stand as evidence. The suggestion 'Anderson and another Senior official had also implicated on the basis of privileged information a Polish Jew', never apparently named by Anderson, suggests a much more sinister motive.

It is sad that the *Gazette*, in a laudable attempt to clear Sir William Gull, should unequivocally accuse and condemn an 'uninteresting' and by implication insignificant character such as Kosminsky, who can never now defend himself.

Yours faithfully,

STEPHANIE A AMIEL
Honorary Consultant and Senior Lecturer
Guy's Hospital

Dr Watts reply:

If Dr Amiel had seen the original programme she would have perhaps more readily appreciated that my purpose in writing this article was, first, to draw attention to a programme that positively

excluded Sir William Gull as a suspect for Jack the Ripper and, second, to repeat some of the points made that I thought would interest *Gazette* readers together with a few comments of my own. It is obvious that I found the ATV argument convincing but I must stress that, for me, its strength lay in the consistency of its whole presentation rather than its individual parts. My article was not intended to judge its validity. I would accept, however, that the caption to the figure was too positive but one does not have to read far into the text to reach the qualifying phrase 'identified with fair certainty' which leaves an element of doubt. Was Dr Amiel's use of the word 'unequivocally' (twice) to suggest my acceptance of Kosminsky's guilt, intended to be over-persuasive? The word does not appear in my article. I have to add that I do not share Dr Amiel's statement of faith that Gull was innocent. Status may prove no deterrant to committing heinous crimes if the motive is strong enough, although it might provide useful cover!

Among the omissions from my article were details of the lengths to which the ATV team went to authenticate Donald Swanson's marginal notes, so disparaged by Dr Amiel, pointing to his view of the culprit. But this information led to the appreciation that Kosminsky had been identified by Schwartz in the act of committing one murder. And further, to the uncovering of evidence of the police-arranged confrontation of Kosminsky by Schwartz at a secret rendezvous (identified as a police home) in Brighton. But most telling of all, that there were no further attacks after this event. Was it chance that this evidence was there to be found once the finger had been pointed in the right direction?

I deliberately glossed over ATV's rather lengthy analysis of Kosminsky's personality which, I am sure, was intended to determine his psychological capacity to commit such crimes. But I would challenge anybody, other than perhaps a criminal psychologist, to demonstrate that, when compared with Sir William Gull, Kosminsky is anything other than 'uninteresting' as Dr Amiel would apparently wish to dispute. The word was chosen for brevity to avoid the national, psychological and, particularly, anti-semitic aspects which, unlike Dr Amiel, I am unable to comment on. However, maybe I should have mentioned that the programme gave considerable air time to a Rabbi who supported its claim about the effects of anti-Jewish feeling. No doubt a whole programme could be devoted to this one issue but that is not the nature of television. I wrote that the police 'prudently' witheld his name; 'of necessity' would have been more accurate as without Schwartz's testimony they had no case in law, even if they felt that they knew the truth. As Dr Amiel correctly states, they 'publicly' failed to solve the crime.

The remaining swings of Dr Amiel's verbal hatchet are so wide of the mark that I wonder if she actually read the article? I did not suggest that Sir William Gull had no surgical knowledge—quite the contrary. But I did comment that the programme avoided considering whether the nature of the attacks were deliberately intended to mislead. Nor did I say that Kosminsky was a barber-surgeon but drew attention to their historical link, that much closer than it is today, as a possible source of the murder weapon for one who was himself a barber. But both these 'uncritical' asides were not part of ATV's presentation so their standing as evidence does not arise.

Poor Kosminsky, like Sir William Gull,

cannot answer for himself. Today, he would even be thrown out of Colney Hatch which he would still recognise, as he might the alternative—one of our Victorian prisons. Quite what he would say about the present government's ambition to 'make Britain Great again' by a return to the Victorian capitalism that created the unspeakable squalor in which he contrived to live, is best left to the individual imagination.

The diversity of experts who contributed to the ATV programme found no cause to disagree with its conclusion. Those who would disagree must study the evidence and present a cogent argument, preferably without recourse to unspecified 'sinister motives'.

Finally, as I am sure Dr Amiel must realize, the *Gazette*, of course, has made no attempt, laudable or otherwise, to clear Sir William. It has fulfilled its proper role in giving publicity to the fact that such an attempt has been made.

D C WATTS
Reader in Biochemistry
Guy's Hospital

More Praise For The Spit

Dear Sir,

Damn, damn, damn and damn again. Having been at Guy's on and off for almost 30 years I was hoping at last to achieve a first. I was going to write a letter to the *Gazette* actually complementing the Spit, but Grub, blast him, has pipped me to the post.

I was going to write about the Spit breakfasts. Is there another hospital canteen where one can get kippers or smoked haddock, black pudding or bubble and squeak, mushrooms, tomatoes grilled and fried, sausages, bacon, fried eggs and scrambled eggs? And the Spit opens at 7 in the morning. It is a pity that the other half of UMDS (the one with the canteen looking straight into the Houses of Parliament) cannot match this.

I never thought that I would write this but: 'Well done the Spit'.

Yours faithfully,

J E DUSSEK FRCS
Consultant Thoracic Surgeon
Guy's Hospital

Guy's Graduates in Belgium

Dear Sir,

I was wondering if any Guy's graduates (from any discipline) living in Belgium or neighbouring regions of other countries might be interested in forming a society. If so, would they kindly contact me at the address given below.

The aims and objectives would be rather informal, that is, to hold an occasional reunion dinner and also to offer advice to other Guy's persons considering moving to that part of Europe.

Yours faithfully,

Dr M St G WHEELEY (Guy's 1969–72)
c/o Bristol-Myers Squibb International Corporation
Chaussée de la Hulpe 154
B–1170 Brussels
Belgium

South Wales Guy's Hospital Society

The society held their fortieth annual dinner at the Park Hotel, Cardiff on 16 February 1991. The guests of honour were Miss Margaret Thom and Mr Michael Maberley. The President, Mr Nat Howells, continued in office owing to the temporary indisposition of Mr I Rocker, President-elect.

Next year's President is to be Mr Christopher Lewis. New members are welcome, both men and women. The next dinner will be March 1992.

All enquiries to Hon Sec, Mr Graham Davies (tel: 0222 842479).

Perils of Passive Smoking

A report endorsed by 48 medical organisations has warned that 300 people are killed every year as a result of passive smoking, and that it causes many babies to suffer from bronchitis and pneumonia.

Another study, among 10,000 British children followed from birth to age 10, showed a 4% increase in childhood bronchitis when members smoked more than four cigarettes a day, and a 49% increase where mothers smoked more than fourteen cigarettes a day.

Below: (l to r) Miss Margaret Thom, Mr Nat Howells, Mr Michael Maberley

Guy's £1.5 million In The Red

The Hospital is now overspent by £1.6 million. However, since December expenditure is slowing down. The overspend figure can be adjusted down if funding from the Evelina Appeal and the income shortfall for Nuffield House is taken into account.

The Hospital has lately been considering the budget for the next financial year, which will be substantially reduced.

Guy's Hospital Food

Research by the *Guild of Food Writers* has shown that many hospital patients are disgusted with the awful food they are given. Tales of cold or inedible foods and soups of unknown origins abound, with some patients relying on food brought by relatives.

The *Guild* has been working with chefs at Guy's to devise new menus, the first of which will be introduced in June. More tempting and exotic menus have been planned—and this on a grand budget of 85 pence per meal.

Mr Leonard Evans

Mr Len Evans, manager of the National Westminster Bank at Guy's Hospital, will retire on 31 May. I can say with certainty that many students at Guy's owe Mr Evans a great deal. I am sure that I speak on behalf of all at Guy's, in wishing Mr Evans a happy and enjoyable retirement.

Friend's Day

The Friends of Guy's Hospital will be holding 'Friend's Day' on Thursday 6 June, 1991 from 11 am until 3 pm in the Park at Guy's.

We hope to publicise the services given by the Friends at the same time providing an occasion to be enjoyed by many people associated with the Hospital.

There will be a barbeque and a tombola, gifts, plants and other stalls. We would be most grateful to receive articles for sale, or donations to buy prizes, which could be left at the Friend's Office situated in the Nurses' Home. We hope to make this a successful fund raising event for the Hospital.

Hours Deal For Junior Doctors

After three months of talks with the Department of Health, it has been agreed that no junior doctor will be contracted to work more than an average of 72 hours per week by January 1 1995. No doctor will work more than 56 hours on a full shift or 64 hours on a partial shift.

The scaling down of hours will be gradual, with contracts for 83 hours per week on normal rotas, 72 hours for partial and 60 hours for full shifts. There will be an attempt to try and remove clerical work from the line of juniors duties, as well as a limit put on the maximum time spent working continuous hours on shift and minimum continuous off-duty hours.

Central Research Fund

The Central Research Fund has been instituted for the purpose of making grants to members of the University (other than present undergraduate students and those registered for a taught Master's degree) engaged on specific projects of research, to assist with the provision of special materials, apparatus and travel costs. Applications are considered each term and the next closing date for applications is **7 September 1991**. Forms of application and further particulars may be obtained from the Central Research Fund Section, Senate House, Room 21a, Malet Street, London WC1E 7HU. Tel: 071–636–8000 Ext. 3147.

Phase III Building Report

The building of Phase III is progressing well. However, the external financing limit from the Department of Health is not enough to allow building of Phase III to be completed. Mr Burroughs is currently negotiating an increase.

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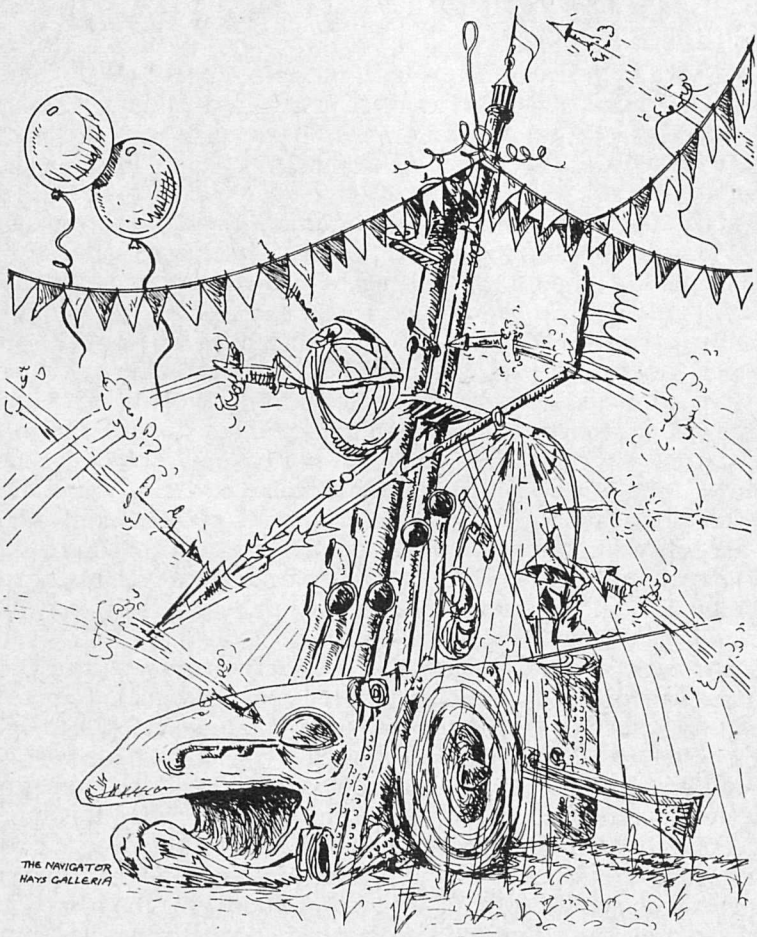

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On Being A GP In The 1920's

The experiences of Mr E D Y Grasby

Dr X caught the midnight boat as arranged, and I said I would come down the following evening to 'learn the ropes' and find out my duties. 'I hope there will not be a night call', was my final good night.

Mrs X had prepared the lists and gave me a brief run down of the work. Morning surgery at half past eight, visits during the morning, and afternoon if there were a lot, and evening surgery at six o'clock. With luck I would get dinner at half past eight, go to bed and hope there would be no night call. Otherwise, the rest of the day was my own! I have never worked so hard in my life. My first list of visits numbered twenty six. I also found that I was acting assistant surgeon at St Barts, Rochester, with an OP session on Tuesdays, I was anaesthetist to the hospital one morning a week, and also conducted a Skin Clinic on Friday evening from five o'clock onwards. I had thought the gaps in the daily surgeries were time off—not more duties. My only relief was the pleasure of driving his splendid Humber car.

It is easy to see how reputations can be quickly made—or lost. One of my first visits was to a baby suffering from feeding difficulties. I arrived at the house at ten fifteen. It was in the middle of the ten o'clock feed and I was greeted by the clearest example of projectile vomiting I had ever seen, and there was a palpable lump in the baby's abdomen. I told the mother her baby had congenital hypertrophic pyloric stenosis and needed an operation. I arranged for the baby to be taken to Guy's, where a Ramstedt was carried out with complete success. In due course Mrs X was told of the brilliantly clever young doctor doing Dr X's work: 'Walked into the room, took one look at the baby, sent him to London for operation and the baby's fine now. Knew exactly what was the matter, he did'.

I wasn't so clever with a man I saw in out-patients. He had a curious sharp pointed thing, like a tooth, sticking out of his palate, right in the middle, and I couldn't for the life of me think what it could be. I'd certainly never seen anything like it before. Fortunately there was a very experienced surgeon in the Hospital and I asked him to see the man. 'Yes, I've seen that before. You have a Wassermann done' was his advice. Then the penny dropped. It was a syphilitic penetrating ulcer of the palate and the spike was a sequestrum from

bony necrosis. I'd never seen one before but we did see quite a lot of secondary and tertiary syphilitic manifestations years ago at Guy's, such as *tabes dorsalis*, Charcot's joints (I saw one of these at both clinicals in the Conjoint and the MBBS) and General Paralysis of the Insane.

I was not called upon to give an anaesthetic nor for an emergency operation and my skin clinics were resolved by writing '*Rep Ung*'; I knew little about dermatology, although we were admirably taught by Dr Barber as students. His registrar was G B Dowling, who went to St Thomas'. My wife thought he was wonderful when he saw her for a minor rash on her hands. 'You mustn't do any heavy housework, like dusting,' he told her, an observation frequently quoted by her to me afterwards!

General practice seemed a continual round of surgeries and visits; I don't suppose I sat down for more than an hour from eight thirty in the mornings until eight at night, with intervals for lunch and, with luck, five minutes for a cup of tea. I don't know how Dr X could go on doing it day after day; two weeks nearly killed me and Mrs X did all the records and clerical work. She was quite splendid.

Dr X came back from Switzerland, sunburnt and refreshed, and I was jolly glad to see him. I had horrid fears he might break a leg and I would be committed to more of his treadmill. I returned, thankfully, to my family.

I had a blissful holiday with them touring in Scotland and when we returned I had to think of getting a job. I consulted the *Lancet* and *BMJ*, and read of an RMO post at Pembury Infirmary, salary £250 per annum, a flat and a small car allowance. It sounded too good to be true. None of us knew where Pembury was, except that it was in Kent, but we looked it up and decided to see the place. We drove over on a sparkling day in June and first saw the Infimary from the road.

E D Y Grasby

On Being A GP In The 1990's

A personal appraisal by Dr I M Stone

Now is an uncertain moment for those contemplating a career in general practice. The new contract has been running for one year and the first weeks of the most pervasive reform of the health service since its inception have just passed.

The essence of general practice has however been as yet little affected (though the crunch may be yet to come).

General practitioners are retained by the health service on an independent contractor basis via locally based bodies called Family Health Service Authorities (FHSA's). This independence is mitigated by nationally imposed terms of service, now considerably modified in the 'new contract'. GPs still nonetheless, have a much freer reign over clinical and organisational matters than their hospital consultant peers.

General Practice is also effectively a small business and the new changes have served to underline this status considerably. New payment mechanisms, such as immunisation targets and child developmental surveillance have led to widespread reappraisal of workload and organisation in the light of the newly emerging commercial climate.

The requirements for entry to general practice are determined by the Joint Training Committee run by the Royal College of General Practitioners and the General Medical Council. The details are far too arcane for the scope of this article but broadly speaking the training comprises a minimum of 3 post-registration years spent as 1 year as a trainee attached to a training practice and 2 years in a series of proscribed hospital posts chosen for their relevance to general practice. These so-called 'schemes' can be completed either as part of an organised Vocational Training Scheme (VTS) or on a DIY basis with jobs arranged individually.

The former allow a certain amount of settling down of one's personal life as a result of job security. Many District General Hospitals offer VTS's run by local course organisers. The latter permit greater choice of particular hospital jobs and freedom to seek out a training practice suited to the trainee's attitudes and interests. The trainee year should provide an initially 'sheltered' millieu for a trainee to try their hand.

There is often an intensely personal relationship between a trainer and trainee which makes correct match essential. One-to-one teaching and supervision during the trainee year is the strength of any VTS. In addition trainees meet locally for joint teaching and discussion.

Nowadays, the need for additional qualifications beyond completing a VTS is strongly felt. Diplomas in Obstetrics, Child Health, geriatric medicine and Family Planning are the most popular and appropriate to general practice.

However, the main qualification that trainees aim to acquire is MRCGP. This is a somewhat maverick exam involving a variety of tests (MCQ, written and viva voce) some of which are techniques of assessment as yet unheard of elsewhere in postgraduate exams.

Becoming a GP principal and partner is still a somewhat fraught and haphazard procedure. Jobs may be advertised or arise 'on the grapevine' (the latter often aiding local trainees). Because entry to solo practice is limited largely to experienced GPs nearly all candidates opt to apply to join a partnership.

Setting aside differences due to geography, such as between urban and rural settings, there are manifold variations in practice styles and types of organisation. This is one of the great strengths of general practice but does present a dilemma to aspirant GPs in that joining a partnership is similar in many ways to a marriage; those holding out for a perfect match may miss chances which, with flexibility, may have worked well enough.

Clinically speaking, general practice offers considerably more autonomy than hospital-based specialities, and that from an earlier stage in the doctors' career. Coupling the advantages of continuity of care, often over decades, and the possibility of getting to know several generations of the family, it is easy to see why the clinical work can be so satisfying. Set against this are the disadvantages of a mounting administrative workload and the repercussions to family and social life of a career-long on-call commitment.

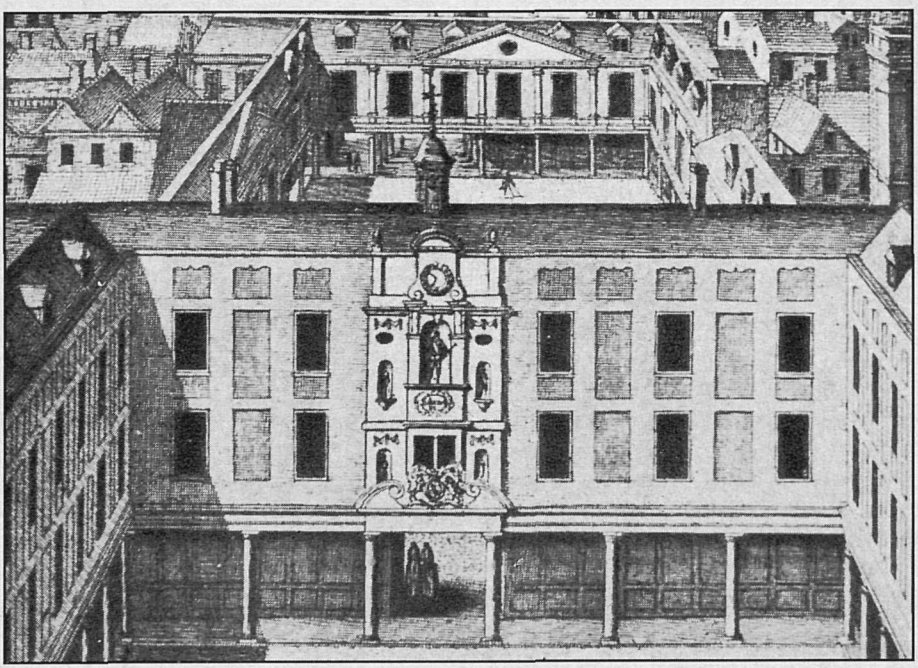
Indeed debate is currently raging over whether, having witnessed considerable erosion of clinical and organisational freedoms, GPs are left largely with the disadvantages of independent contractor status such as the above mentioned on-call responsibility (in theory 24 hours a day, 365 days a year) which is remunerated, even after the new contract, at rates a plumber or electrician, let alone a lawyer or vet, would turn their nose up at. The views of all GPs will soon be sought on this issue and the related proposal of a salaried service, as in hospitals. In short, general practice remains a very attractive and viable career option, though one can't help feeling that some of the gloss, perhaps at its shiniest in the 70's and 80's has been dulled somewhat (hopefully only temporarily) by the insensitive machinations of the Department of Health.

The Operating Theatre Museum

A Step back in time

St Thomas' Hospital had occupied a site near London Bridge since the twelfth century, but in June 1862 it was forced to move to make way for a new railway line from London Bridge to Charing Cross. However, the Hospital left more behind than just the name of its incredulous patron saint; for in the attic of what used to be the Parish Church of St Thomas' (now the Chapter House of Southwark Cathedral) is the old women's operating theatre.

Fig 1: St Thomas' Hospital (circa 1720). The block on the left was built by Thomas Guy (1707) and that on the right by Thomas Frederick.



The operating theatre was built in 1821, when Guy's and St Thomas' Hospitals together formed the United Borough Hospitals, and sustained a common medical school. St Thomas' Hospital, as it stood then, was a result of the rebuilding of the medieval hospital. The front entrance was in Borough High Street and from this courtyards stretched eastwards, roughly parallel with St Thomas' Street. The surgical block, which was on the south side of the Front Square and abutted directly on the Parish Church (Fig 1), contained three wards. Lydia ward was on the ground floor, Queen's in the middle and Dorcas on the top floor, level with the church attic. A door connected the attic theatre to Dorcas ward, and patients could be brought direct into the theatre (Fig 2).

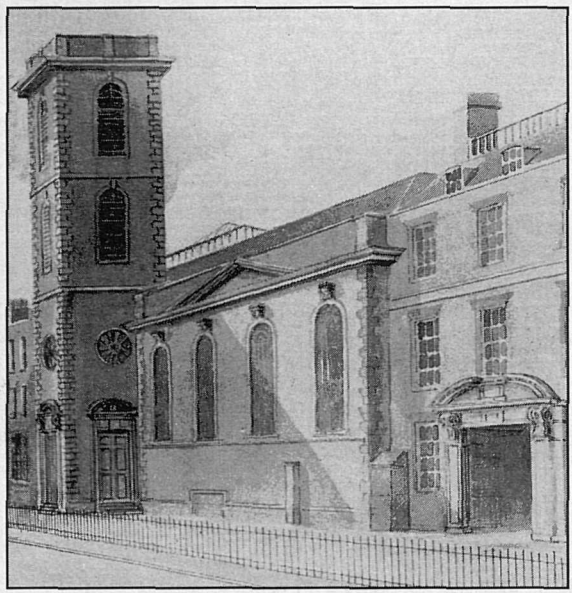


Fig 2: St Thomas' Church in 1825, showing skylight of the female operating theatre.

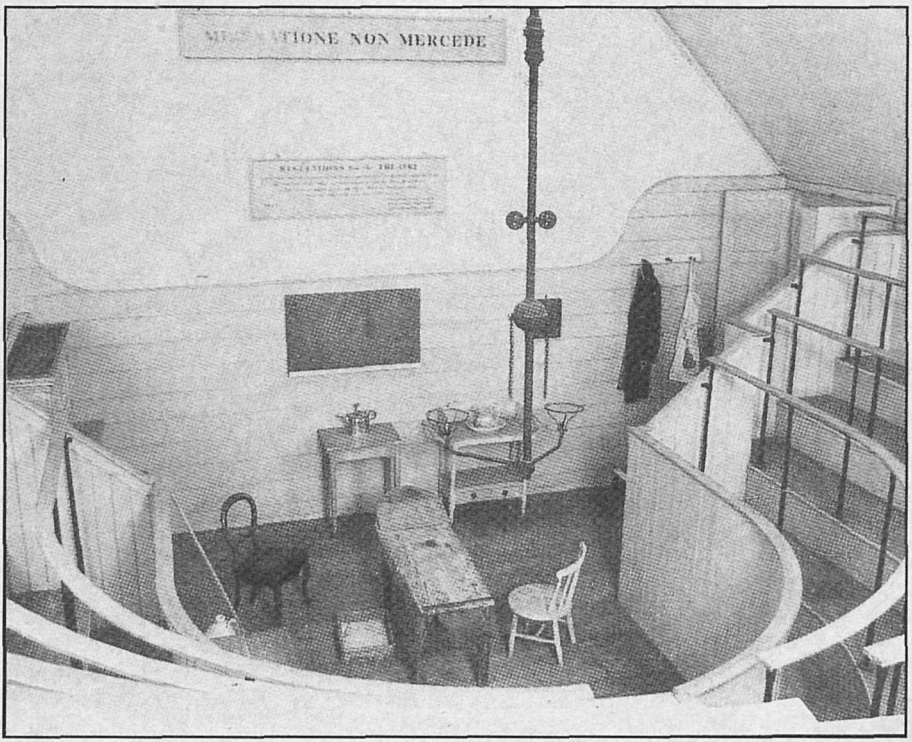
The rebuilding of London Bridge (1824–1831) led to alterations within St Thomas' Hospital. First the new approach was about 180 feet west of the old one and thus gave more space between the front entrance and the new line of Borough High Street; second the road level on the new bridge was higher than the old one, so an incline had to be constructed and the level of the

Front Square had to be raised. The two old wings built by Guy and Frederick (Fig 1) were therefore demolished and two new blocks were built on a higher level and on a grander scale.

It had been intended that this should be followed by the rebuilding of the whole Hospital, but since the new railway line would pass within 18 inches of the new surgical block, St Thomas' was forced to move. The site was sold to the South Eastern Railway Company; most of the Hospital buildings were demolished, but the southern surgical wing still stands and is now the Post Office in Borough High Street.

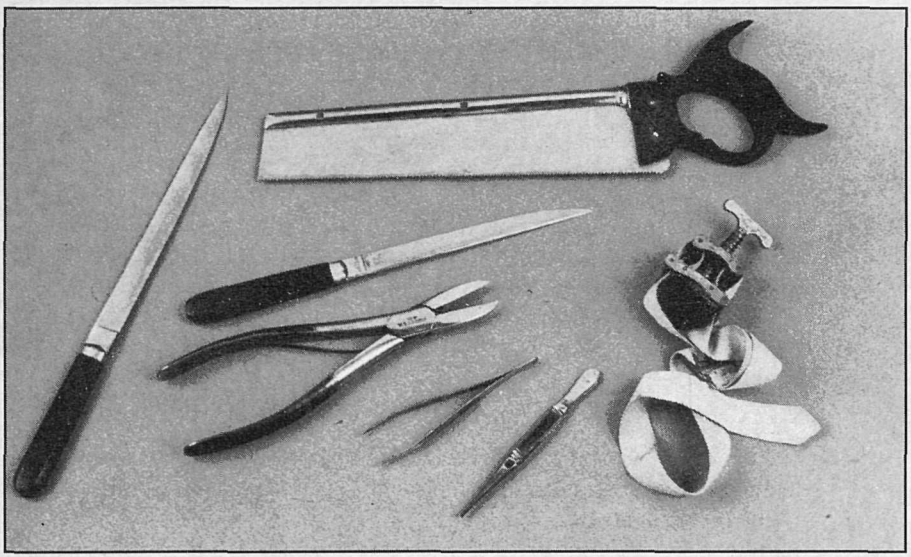
The operating theatre, which subsequently lay undiscovered for more than one hundred years, has been fully restored, thanks to the determined efforts of many people, notably Mr Raymond Russell and Lord Brock. A rather difficult climb up a tortuous spiral staircase leads one back to the beginning of the nineteenth century (Fig 3).

Fig 3: old St Thomas' operating theatre



The patient would have entered a small ante room direct from the ward, and here she would have been prepared for her operation. It is hard to imagine these women's terror. Until 1847 no operations used anaesthetic: the patient would be given a strip of leather to bite on during the operation and, depending on the surgeon, she might have been blindfolded.

Fig 4: an early nineteenth century amputation set



There were two reasons for the blindfold. Firstly, the instruments would already have been laid out on the table (Fig 4), and the sight of these would surely have sapped any remaining courage; secondly, the operating theatre would be literally full of people. In the five rows of standings (Fig 3) that surround the theatre were the students—packed, according to one contemporary description, 'like herrings in a barrel'. If an important surgeon was operating, or if the case was of particular interest, then student admission was by ticket only.

On the floor of the theatre stood the surgeon. He was probably the only person to remove his outdoor coat, which the more advanced surgeons swapped for an apron, although it would probably still be soiled from previous

Fig 5: 'The Good Old Days'

operations (antiseptic technique had yet to be discovered). Although there was a hand basin in the theatre, the surgeon would most often use this after, rather than before, the operation.

Assisting the surgeon would be his dressers and apprentices, they would keep the place tidy, mop up any spillages and generally help with the operation. The surgeon could also invite guests. They would be offered a chair at the front, ensuring both a comfortable seat and a good view. The patient would have been the only woman in the crowd. John Flint wrote in his Memorials: 'I have often known even the floor so crowded that the surgeon could not operate till it had been partially cleared'.

Most routine operations were done by natural light from the skylight (Fig 2) but this would have been inadequate on dark or foggy days. On such occasions, portable gas burners with 12 feet of flexible tubing were used. There was no plumbing, no heating and no ventilation in the operating theatre.

For operations during this period, speed was of the essence (Fig 5). Amputation was the most common operation to be performed, and it was quite common for a limb to be removed within one minute. A box of sawdust was used to catch the blood as it ran from the table, and the assistants mopped up any blood on the floor (sawdust packed beneath the floorboards prevented any blood from staining the ceiling of the church below).

It is impossible to imagine the horrendous scenes witnessed in this operating theatre—it is considerably easier to understand why many people refused to 'go under the knife'.

In 1871, 3,043 surgical patients were admitted; 316 had an operation and of these 76 died.

The small museum, which would benefit from more lighting, is interesting. For example, in the nineteenth century patients were given 12 oz bread and 1 gallon (8 pints) of beer every day. The bread ration could be reduced because of 'illness, disorderly behaviour, staying out of the Hospital late at night, refusing to do menial work set for them by the ward sister'. One particularly memorable print was of the surgical correction of an ingrowing toe nail: they use to chisel off the offending toe.

All in all, I think that the operating theatre and museum are well worth a visit.

TAP

The Old Operating Theatre, Museum and Herb Garret is situated at 9A St Thomas' St, SE1 (2 mins walk from London Bridge Underground, and just about opposite the main gates to Guy's Hospital). It is open Mon, Wed and Fri 12.30–4.00 pm, and other times by arrangement (071-955 4791). Entrance costs £1.00.

The building is available to hire for receptions, lectures and theatrical performances. An educational programme of lectures and historical walks has also been organised (on such varied topics as Florence Nightingale or The Black Death) and details of these can be obtained by ringing the telephone number above.

Gas! Gas! Gas! (Part 2)

Saddam, our part in his downfall

Greetings from Tabuk!

Operation Desert Storm began on 17 January 1991 amidst great secrecy. Most of our information came from the Yank's local FM station and more British news via the ever reliable BBC World Service.

It began for us with several 'Red Alerts'. This meant donning your respirator within 9 seconds, putting on your NBC suits and rushing to the nearest air raid shelter. We were vulnerable to SCUD attacks as we were close to Israel; time from launch to impact was just seven to eight minutes.

Our dining room was converted into a big NBC shelter, the windows covered with plastic sheets and heavy duty tape. We carried our webbing and respirator with us all the time. Sleep patterns were disrupted, meal times became erratic and there was a continuous noise from aircraft either taking off or landing.

Tabuk, by Saudi standards is small, but it was the base for Saudi F5's, British Tornadoes, USAF F15's. Although our planes made up only 2 per cent of the Allied total, they were responsible for 4 per cent of the missions undertaken. The Tornadoes would refuel in midflight from VC 10 tankers for any sorties into enemy territory.

On 18 January Israel was attacked by SCUD's. There was suspicion that these missiles could carry nerve or biological agents. So we were started on pyridostigmine (30 mg, 8 hourly) as nerve agent prophylaxis; most of us noted no ill effects, except for the increased volume of flatus passed. The charcoal lining of the NBC suits kept the problem within socially acceptable limits.

We obtained a ground role resuscitator that ran our 10 Pneupac ventilators for use in nerve agent poisoned patients with respiratory difficulty. Fortunately, the medics had experience in intubations and in the use of the Pneupac ventilators during the ambulance strike. Meanwhile I was busy updating myself on the problems of anaesthetising the nerve agent poisoned patient. The Poisons Unit at Guy's, the British Lending Library and Surgeon Commander Baker of the RN provided useful up-to-date information, in addition to that from normal channels.

As far as biological warfare was concerned, we were innoculated against anthrax and plague. I was off colour for 48 hours after each injection, but at least my innoculation record looked spectacular!

I very much enjoyed the company of my American counterparts. They were fascinated with the Triservice Apparatus (TSA) and Brain's Laryngeal Mask

Above: Field Surgical Team, Tabuk

Airway (LMA). Their field equipment is exactly what they would use in peacetime. They were more experienced in regional anaesthesia and I learnt a great deal from them. We got on well both professionally and socially. We set up the Tabuk Society of Anesthesiologists (TSA) which is dedicated to field anaesthesia. So far we have only four members, but we remain hopeful. A club tie has been designed.

Despite all this, we remained the only facility that could work in a chemically contaminated environment. The war gave little work except for our GP and our dentist. Initially we had a few cases of 'battle shock', and this is when the medics and nurses excelled themselves. The fact that nearly all returned to normal duties within 24 to 48 hours is a credit to them.

Surgically, we had three abcesses to be drained under GA and one other case. The latter was interesting for several reasons. We initially received a radio message warning us of the arrival of a wounded patient. *Six* days later he arrived at our location. He had been shot in the chest whilst on a mission. He got to us via a very circuitous route, involving several vehicles and an

Allied Field Hospital. There, a chest drain was inserted to relieve a massive haemothorax and the GSW entry and exit sites were examined under GA. He was discharged the next day to us. He looked pale and uncomfortable but did not complain. We changed the chest drain and transfused him with two units of blood. He felt much better for that.

The entry site was in the post axillary line at T10 and exit at the anterior axillary line at T12. He had lost an estimated 2,000 mls of blood into the right haemothorax as a result of an AK47 single round. There was no clinical evidence of any other injury (in particular no hepatic or renal damage) so we felt, on balance, that he should be casevaced to the UK. The aeromed Warrant Officer arranged this. On arrival in the UK, he had a CT scan which showed a small liver haematoma. The chest drain (that was left *in situ* for the purposes of the flight) was removed and he was sent home to recuperate 24 hours later.

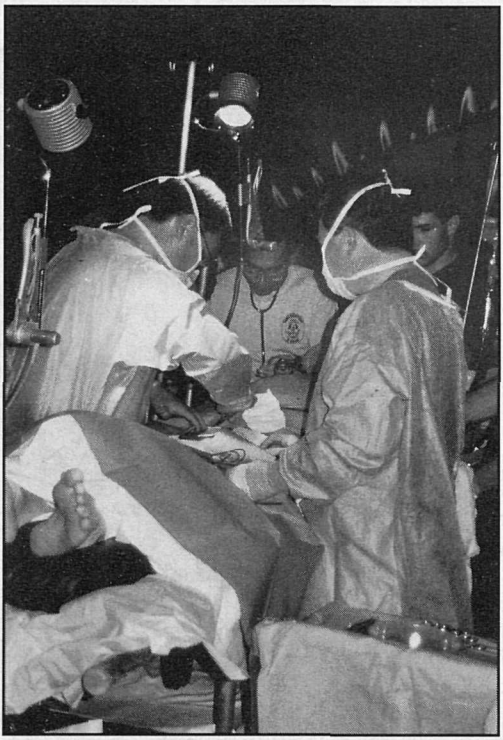
We had eighteen casevacs back to the UK in our tour, and I was impressed by the efficient aeromed service the RAF provides for the military, both in war and in peacetime. The closest British facility for us was at Cyprus; which involves a three hour helicopter flight.

We lost 2 Tornadoes, one due to malfunction which I mentioned in Part 1; and the other, was shot down with the two aircrew reported as MIA (i.e. missing in action). There were three other occasions when aircraft in trouble tried an emergency landing, but fortunately there was no loss of life or aircraft.

Despite the heavy aerial bombardment it was inevitable that the ground war would have to start. It did so amidst great secrecy. As we were miles away from the Kuwaiti theatre of operations, we were not expecting any ground force casualties, although the base was still as busy as ever with sorties. Our concern was a terrorist attack, the threat of SCUD (with or without nerve or biological agent), or a major accident involving one or more of the bomb laden aircraft. Luckily none of these materialised.

I guess we were just as surprised as anybody to find that the ground offensive lasted only 100 hours. There was a great sense of relief, but what hit us hard was the tragic loss of our boys to what is euphemistically known as 'friendly fire'. This neatly brings me to the important role the padres played out here. They were called 'morale officers', in order not to upset the host nation, which is custodian to the Islamic faith. Provided we held our services in private, nobody was bothered. Our padre, Bob, was terrific. He was a good friend, and well-respected by one and all. Fortunately, his professional services were not required, except for special occasions such as Remembrance Sunday and Christmas Day when his whole sermon was in verse!

We had our times of relaxation. We arranged trips to the Red Sea and to see the ruins of the train blown up by Lawrence of Arabia. We had a barbeque



Above: Appendicectomy in progress

(that was ruined by a SCUD launch) , and a camel race against the Yanks. They won thanks to their 'Stealth' camel, which I am sure was not covered by the Tabuk Treaty.

It was only after the end of hostilities, that I felt able to visit the various sectors on this huge airbase. I saw the Tornadoes in their hardened air shelters, the bomb dump, the Rapier anti-aircraft sites and lastly, but not least, the famous Patriot missile sites. Only then did I appreciate how busy the base had been. The Tornadoes alone had flown 667 combat sorties; dropped 1,867 one thousand pound bombs, 104 Alarm missiles and 40 JP 233's, (which are runway denial bombs). And that was just from Tabuk!

We are now busy packing up our kit and equipment for the journey home. The weather is getting hot again and there has been the occasional sandstorm; its time to go. There is still the post-operational report to be done. Since this was the first time that MST's had been deployed, there have been useful lessons learnt. Only two were deployed to the Gulf: Bravo to Tabuk, and Alpha to Dharan. MST Alpha have been out here since August and is commanded by their surgeon, Ian Crate, who is also a Guy's man.

I am surprised to see how strong the representation of the Irish Colleges is in the Gulf; so it was nice to see Guy's joining in the competition for hospital contracts out here.

Finally thanks to everybody at Guy's who kept in touch and the *Gazette* for this opportunity.

As-salaam alaykum.

Major Winston de Mello, RAMC
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Some Reminiscences Of 1965

My First Term at Guy's

Some of the most evocative words in the English language were written by a chap called H J Buckoll (1803–71) when he wrote hymn 523 in *The English Hymnal*. This fine anthology of ecclesiastical warblings was first published in 1906 and is still in use today.

It was Henry James Buckoll's only contribution to that volume, and though we seem to have been given the same Christian names—only in a different order—I wonder what could have been going through his mind as he wrote verses three and four. In particular the latter stanza always had a strangely gripping effect on me; especially the last time I ever sang it—back in the July of '65. I stood in the choir stalls of the Chapel at Epsom College and mouthed the words—for the simple reason that I did not know whether to laugh or cry. At long last my stay at Epsom had come to an end.

Let thy Father-hand be shielding
All who here shall meet no more;
May their seed time past be yielding
Year by year a richer store:
Those returning
Make more faithful than before. (Verse 4 Hymn 523)

There is much I would wish to say about this school but I shall contain myself until another time. Suffice to say, that quite a few Guy's men went to Epsom. For those keen to get the somewhat Gothic flavour of the Victorian architecture I would commend you to a reading of *Mr Perrin & Mr Traill* (1911) by Hugh Walpole. He had spent a short while there as a schoolmaster in the first years of this century. I am assured that the place is much changed now and there are female pupils, but in my day it was strictly men only. Some five years ago I had dinner in The Grille Room at The House of Commons with Alex Carlile QC, MP who had been a close contemporary in the Classical Sixth and a fellow member of Fayrer House. To hear him speak was to wonder if we had actually attended the same school.

There was a three week wait for the A'level results. There was no such thing as UCCA; in fact, there was—but it was happening to the year after us. My admission to Guy's depended on three pases at A'level and I think that was the general rule for all of us who had passed the selection procedure. I

was cock-a-hoop when I found that I had got two 'D's and an 'E'. The 'E', by the way, was for physics. Those, indeed, were the days.

I shall never forget the kindness of the Medical School Office. There was a man there with a kind face and wavy grey hair—I think it was Mr Wallis—and his phenomenal memory for names and faces did much to help in the early days of 'lostness' that happens in big places. The term started in October and that time of year has been a favourite of mine ever since. There were about a hundred of us, maybe a hundred and ten, and if I may say so it was proof-positive that the old selection procedure was every bit as good as that of today.

I had read every word of that book by Richard Gordon: *Doctor in The House*—so that I might be prepared for what was to come. I had seen the film too. I think a lot of us had done that. The Dean was Dr Houston and he was the first to speak to us in the Anatomy Theatre or was it The Physiology Theatre? That's the trouble with trying to remember. Some of his words did stick with me. Life at Guy's was what we made it, he said, and we would only get out of it what we put into it. Good sound stuff along the Tom Lehrer maxim about sewers; which function in the same sort of way.

We were Freshers; and there was a Freshers' Tea—quite a noisy affair with much heckling of the speakers and a lot of laughter. And a Freshers' Hop—very noisy and sweaty. In all the years I attended these Hops I do not ever remember getting off with a single nurse. The girls all sat down on the periphery while freshers stood in the centre staring into the middle distance. What was I thinking about? Life at that school hadn't equipped me for any of this.

The main subjects of the day when we started were anatomy, physiology, and biochemistry. It was the biochemistry practicals that made me wonder if I'd done the right thing. We pottered about with Benedict's reagent learning what was quantitative and what was qualitative. An aptly-named Dr Brain supervised our grapplings with the mysteries of the King-Armstrong unit. One Christmas he cracked a joke.

Professor Warwick was in charge of anatomy although the Anatomy Departmet seemed to be charged with professors *viz* Professor Joseph and Professor Williams. I distinctly remember being told what a privilege it was to dissect the 'uman (Prof Warwick always pronounced it without an 'h') body but I was dashed if I could see it to begin with. The greasiness of the hands after a session there was tiresome, and the smell of the carbolic soap awful, and it all got under the fingernails. After three weeks I was standing in the lunch queue for the Spit one day; had paid for my lunch—when I realised that I had *forgotten* to wash my hands. I carried on eating. I do believe that was when I became a medical student.

Professor Jack Hunt took us for physiology and I shall never forget our first three hour session with him. He used long words which I did not understand; words like 'extrapolate' and 'teliological', and I was somewhat alarmed to find that he would be taking me for the tutorial I had been assigned to. Early on, he told me that I did not think logically. I felt as though I'd just been crapped on from a great height. Everyone has a story about Professor Hunt, but my own memory was that he swallowed a Ryle's tube every morning; aspirated his resting gastric contents; took a test meal; aspirated that after a while, and then sauntered off to the Spit for breakfast. Many joined him in this ritual, but not me.

The Guy's of the mid-sixties still had a campus feel to it; until the old college was knocked down. The surgical block was very new and it was possible to go and watch operations taking place through the observation domes. To a novice it was all very bright red and green down there but we were able to watch Lord Brock in action—even though we didn't know it was him.

There was the Gordon Museum and the Mortuary; places which gave off information like carbon dioxide from dry ice.

Professor Keith Simpson's *post-mortems* were always a pleasure to attend and there was the ever-present Mr Beaney; referred to as 'Beaney' by the Prof, Mr Beaney had used many many miles of brown string in the execution of his job. Not many of us could make a claim like that; that we had used fifteen miles of brown string—or twenty—or even thirty.

In the dissecting room we were divided up into groups. My partners would be Cornelia McCarthy† and Jane Wynburne*. The Dental students were doing head and neck while we did thorax and arm. The Demonstrators walked about from table to table; chaps like Bob Sells and John Keats; men who understood the meaning of the 'lesser sac'.

My overall impression of those early days was that I had joined some kind of extended family. Our teachers, though remote, were interested in us and watched our antics from afar. They were happy days indeed. My advice for today's medical student who is finding the going a bit tough is to look ahead ten years. You may feel a bit unhappy now but in ten years you'll look back and say: 'Those were the days!'

James Henry Pitt-Payne

† now Mrs Black * deceased

David Webber

In a tragic event David died in February 1991, the suddenness and shockingness of his death created an immediate sense of numbness and disbelief.

He had attended Marlborough before starting here at Guy's in October 1977 and qualified in December 1981.

He will be ever remembered by those fortunate enough to meet him, because his philosophy was that one should always live life to the full, and it is doubtful that during all the time he was at play that he ever spent three consecutive minutes doing something he did not enjoy, and what was more important, making certain that everyone in his company was also thoroughly enjoying themselves.

He was of course an eminently good golfer, but never for a moment took it seriously. He won at the Royal Cinque Ports Golf Club at Deal virtually every trophy possible, and had no problem winning our MacDonald cup at Muswell Hill where he went round in a gross 70 (including a lost ball). However he claimed that squash was his real love as you could work up a sweat and a thirst far quicker!

He played squash for Guy's (1979–81) and, known as Swing, could guarantee to start off well against all new opponents due to a devasting psychological blow he inflicted before the game started. As a talented golfer he brought to the squash court an exaggerated swing which during the knock-up enabled him to hit the ball harder and more accurately than is possible for most ordinary mortals. Unfortunately the accuracy rarely persisted when he, as well as the ball, had to move, he had his victories, but most felt they would have been more frequent had he accepted the advice to dedicate more time to training. He played competitive squash when he became commissioned in the Royal Navy, and was so proud to become the fourth generation of his family to serve the sovereign. When he left he bought a partnership in a Guy's practice in Deal where he quickly built up an enviable reputation as a dentist, getting enormous satisfaction from his chosen profession.

David had another great side to his character and that was his immediate concern for the welfare of any of his friends who might be in trouble or difficulty through domestic or other reasons. In these cases he had an ability, far beyond his years, to listen, to advise, and to do something. David in fact practised to the full those two great principles of life—beneficence and charity (love).

He will always be remembered wherever he went for his signature tune—that infectious laugh ringing out in golf clubs, hostelries, galleys, messroom, and even in the surgery!

He will leave behind a legacy of this laugh and good sportsmanship which will I hope, with our thoughts and prayers, fortify and sustain his parents and family during this agonising time.

JDH

David Webber

Gilbert John Parfitt FDS, MRCS, LRCP, DMD

His many friends and admirers throughout the world will be saddened to read of the death recently of Gilbert Parfitt in California, at the age of 80 years. The son of G B Parfitt, a famous teacher in the Dental School at Guy's he completed his combined Medical and Dental course at Guy's in 1939, just before war was declared. Having shown a keen interest in children's dentistry, with a very successful House Surgeon's appointment and the invention of an orthodontic welder to his credit, he nevertheless elected to enter the EMS and accordingly joined Kelsey Fry and his team at the Queen Victoria Hospital in East Grinstead.

By the end of the war he had gained a considerable reputation as an Oral Surgeon and, as one of the four authors of the classic text, *Dental Treatment of Maxillo-facial Injuries* a future in oral surgery seemed assured. However, his first love was preventive dentistry and, having returned to Guy's as a Registrar in the Dental Department for Children, he was the obvious choice for the appointment of Director (part-time) of the newly established Department of Preventive Dentistry, made possible by a grant from the Nuffield Foundation in 1946. Space was at a premium in the old Dental School, and this Cinderella department was housed in a corner of the Conservation Room. Small wonder that when the new Post-graduate Institute was opened at the Eastman Hospital in Grays Inn Road, Gil was attracted to the full-time Directorship of the Preventive Dentistry Department in 1949.

During the ensuing six years the aetiology and epidemiology of dental caries were his main research interest. An important paper in the *British Dental Journal* with Jean Forrest as co-author confirmed the anti-caries effect of 1–1.5 ppm fluoride in drinking water and indicated the safety of water fluoridation in this country. In collaboration with Peter James he studied the buffering capacity of saliva in relation to *Bacillus acidophilus* and caries. They also formed the dental team in the on-going growth studies on children in Harpenden.

Unfortunately his first marriage ended in divorce, but with his charming second wife, Muriel, he embarked on a new life on the other side of the Atlantic. His first post in 1955 was Assistant Professor in Birmingham, Alabama, where one of his research projects was the measurement of physiological mobility of teeth. However, he and Muriel did not adjust happily to the racial discrimination in Birmingham at that time and an invitation to Vancouver as Professor and Head of the Department of Oral Medicine at the University of British Columbia was readily accepted. In due course, he became the Head of the Faculty of Dentistry.

In the beautiful campus of the University where they lived, life was good, and a weekend cottage further up the coast provided a delightful retreat in the primitive temperate rain-forest. Here Muriel had a pottery kiln and Gil had plenty of scope for his photographic interests in forest fungi.

However, a serious road accident forced an earlier retirement than expected, but happily no permanent disability was apparent. In fact they were able to enjoy Hawaii in winter and British Columbia or California (where his son lives) in summer.

Sadly, the progressive development of Parkinson's Disease increasingly limited his activities during the final years, but despite this he never lost his sense of humour and wit.

The deepest sympathies of all his many friends and students on both sides of the Atlantic are extended to Muriel, and to his son and daughter.

R D Emslie

Richard Brook Sutcliffe, MB BChir FRCS

The death of Brook Sutcliffe in Guernsey at the age of 85 on 22 January has removed one of the last and most devoted Guy's men of the inter-war years, the heyday of such legendary figures as T B Johnston, John Ryle, Arthur Hurst and Joey Hughes. There are not likely to be many at Guy's now who remember him, but he remembered Guy's vividly for over 60 years. Guy's owes to him its link with Guernsey since the war. The breast cancer research project which was started by Sir Hedley Atkins in 1961 was one of its fruits.

Born in 1904, Dr Sutcliffe was educated at Sedbergh and St Johns College Cambridge, going on to Guy's in 1927. He qualified in 1931 and became President of the Residents. His contemporaries included Hedley Atkins, J S Batchelor, Nils Eckoff, Keith Simpson, John Blaikley, Peter Bishop and Philip Reading. After a year of house appointments in which he learned enough surgery to become a GP surgeon he joined a practice in Essex, but in 1937 he moved to Guernsey as partner of Dr Montague, whose daughter Mary later became one of Guy's first women medical students.

He received a testing initiation. On Brook's first day in Guernsey Dr Montague fell sick and he was left to take over the care of a woman in labour. She was in her second pregnancy, having previously had a classical Caesarian section. Brook examined a very ill woman and realised that her uterus had ruptured and the young GP had to deal with, to him, a totally novel situation. He operated successfully and the mother survived.

In those days in Guernsey, all doctors were general practitioners, whatever their special interest. Brook had only two years in the practice before the outbreak of war in 1939. His partner, Dr Montague, was advised to return to England shortly before the occupation of the Island by the Germans in 1940, as he was Jewish. Brook had no doubt that his duty was to stay with his patients and he remained in Guernsey for the five years of occupation. He showed great courage. In the first days of the occupation one of his patients was raped by a German soldier. Brook immediately complained to the German authorities and the soldier was court martialled. Brook played a leading part in keeping a medical service running, under conditions of increasing difficulty (in the

last year there was near starvation on the Island). He gave up his car and went round on a motor cycle. On Liberation Day, 9 May 1945, Brook shot a colour film of the events, using a film which he had successfully concealed for the duration of the war. Part of this film, including a shot of Brook himself, can be seen in the Guernsey Occupation Museum.

After the war he had another 25 years in practice and his reputation was such that he was awarded an honorary FRCS. He was a safe surgeon, aware of his limitations, and always looked to Guy's when he needed help. He was a good friend of Sir Heneage Ogilvie who became a frequent visitor to the Island. F R Kilpatrick and Noel Glover came occasionally and George Scott visited Guernsey regularly.

Brook was a member of the Board of Health in Guernsey and played a prominent part in planning the new extension to the Princess Elizabeth Hospital. Opened in 1974 by the Queen Mother, this included new surgical wards, theatres, an intensive care unit, CSSD and a pharmacy. It involved much new thinking. Brook tackled all this with characteristic thoroughness, attention to detail and plain speaking.

Brook retired from practice in 1972 and received a high honour, the office of Jurat. Jurats assist the Bailiff, the chief law officer of the Crown, in the Royal Court. Later he became a magistrate, which further enhanced his reputation and led to his undertaking the thorny responsibility of officer for industrial disputes.

His wife Eileen died in 1981, but he continued to live alone in spite of increasing disability from osteoarthritic hips. He was wonderfully supported by a neighbour, Gwen McCave. At the end of his life he developed malignant disease of the bladder and had several admissions to hospital. Eventually he declined heroic surgery and died peacefully. He modestly directed that his funeral should be attended only by his family. His mind and his memory remained sharp to the very end. He was a man of high standards and did not suffer fools gladly, but there were plenty of people for whom he had a high regard. He was a delightful guest and liked nothing better than to reminisce about Guy's and show off his photographs of the days when he was president of the residents sixty years ago.

REI
JRD

Grease Lightning

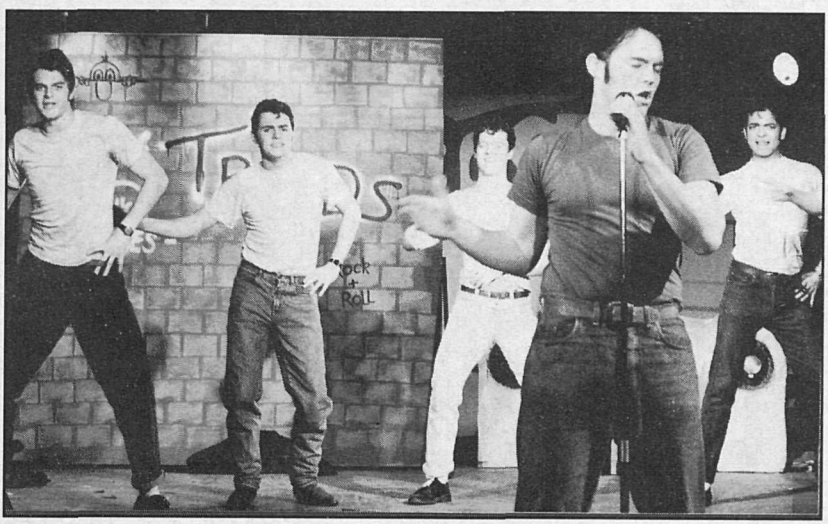
Who in the world said Guy's and St Thomas couldn't stage a successful box-office production? *Grease* was a musical extravaganza which I'm sure left even the notorious back-benchers mesmerised. The various blasts of notoriety from the so-called well-wishers and barfolk, together with the American teenage humour on stage, brought laughter and thrills to the audience. However the best clips from the play were those involving duet and group singing, such as the *Oh! Grease lightning*, set played by Danny (Jolyon Ford) and his black leather jacketed chums, who danced around a pink cardboard Morris Minor, gyrating and performing a mild form of Jane Fonda's workout.

The lass who acted the 'major hit lady' of Danny's group displayed her excellent talent by singing the *Sandradee* song. Her singing was greatly influenced by wild tension-relieving gestures, lip-thrusting and Hale and Pace leg-stonking; however I must most sincerely say that her act was convincing and eloquently performed. Well done Frenchy (Louise Gumpert).

The most tantalizing extract from the play (probably a filler for time) was the dream sequence performed by Mr Teen Angel (Nick Degge) himself, three pink robed ladies and fumes of smoke. The sequence was well acted; however we may ask ourselves 'Where did they get those pink towels?'—probably from Jackie Collin's' hotel suite.

And now moving onto Sandra (Tracy Williams)—the soft hearted angelic teenager in love with Biology. Sandra played her part well and did get her way at the end of the show. Excellent vocals, superb outfits and good choreography was displayed by all our fine actors and actresses.

Well I suppose the *Grease* fever is not over yet. Will we see *Grease 2* or *Saturday Night Fever*? We'll have to wait and see!



Essentials of Respiratory Disease. R B Cole & A B Mackay. Edinburgh: Churchill Livingstone, 1990

This is the third edition of this introduction to chest disease. The first forty pages deal with history, examination and investigation, then forty pages with structure and function, and the next 170 pages with specific disorders. There is a useful section on physiology and respiratory function which brings the basic science and the clinical aspects together.

The clinical chapters have a rather dated feel to them despite this fresh edition. They would benefit from an improved layout with greater use of illustrations and tables. Within the text some important points have been set out in numbered lists. The coverage is reasonably comprehensive, and adequate for finals, but the approach is probably not practical enough for postgraduates. It is a reasonable choice for students but it enters a field in which there is a lot of choice. The second edition of Flenley's book *Respiratory Medicine* leads the field.

John Rees

Diagnostic Picture Tests in Urology— George N J R, Sanbrook P. Wolfe Publishing Ltd Price £7.95

This is an interesting and amusing little book that I have enjoyed reading. The authors hope that both 'under-graduate and post-graduate students will benefit from this educational approach'. I am sure they will, but I suspect this is of more value to post-graduates than under-graduates. I tried answering the questions and then marking myself (honestly) and actually didn't do dreadfully well. Perhaps this is a reflection on my knowledge of general urology, but in part it is due to the rather variable quality of the x-rays and particularly the operative photographs, and in part it is due to the fact that the type of questions that the authors pose are always difficult to create when you already know the answer.

The principle value of this book is in the wide range of conditions illustrated in such a compact format. It would be impossible for any student, under graduate or post graduate, to see such a range in less than a decade and for this reason the book is to be highly recommended. It is not a book that could be studied in isolation—a text book will be needed in addition, but for a post graduate pursuing a career in surgery this will be a very worthwhile edition to his or her library. I still can't understand how figure 177–178 came to happen; answers to the Editor.

A R Mundy
Consultant Urological Surgeon

Oxford Book of Functional Anatomy Vol 3: Head and Neck. P MacKinnon and J Morris. Oxford University Press. 1990. 154 pages.

This is the third book in a 3 volume text series of functional anatomy. Book 1 covers the musculo-skeletal system and book 2 the thorax and abdomen.

The first four chapters are introductory in nature, covering topics such as the systematic approach to tissue study, medical imaging and the embryology of head and neck development.

The main body of the text is divided into seminars. Seminars 1–6 deal systematically with the structural features and movements of the head and neck and with the

upper respiratory and alimentary tracts. Seminars 7–10 cover the interior of the skull, the eye, orbit, ear and blood supply and lymphatic drainage of the region. Seminars 11–14 cover the innervation of the head and neck. Seminar 15 is devoted to cross sectional anatomy of the region as revealed by CT scans. Chapter 7 covers the anatomical rationale behind neural reflexes such as lacrimation, sneezing, swallowing and yawning. Each section of the text contains relevant self test questions and answers.

There is liberal use of diagrams, photographs, radiographs and endoscopic views of both normal and abnormal anatomy.

It must be said that this is a good text, but it should be borne in mind that it must be used in conjunction with a good neuroanatomy text. It is not specifically designed for use as a medical text but rather to give a good overview of the region for any student involved in the study of the biology of man.

Dr S M MacLaughlin
Division of Anatomy and Cell Biology

The Acceptable Weakness In Us All

One of the commonly held misconceptions about the medical profession, is that a career in medicine somehow miraculously immunises you against life's stresses and strains. As a result, by the time you qualify, you are transformed into some kind of superhuman, self-sufficient being that can cope with absolutely anything that life and the NHS cares to throw at you.

However, as the student years pass, your realise that you're still as vulnerable as everyone else, and that even those in the white coats don't hold all the answers. In fact, if anything, many of them have to suffer even more, because real doctors aren't supposed to admit weakness and seek help when they need it.

So while it is alright for the rest of humankind to seek our help, we, for some reason, decide that we should not need to seek help from others.

Fortunately, attitudes do seem to be changing, and as psychosocial medicine takes its place alongside surgery in the curriculum, the stigma associated with mental health problems begins to lessen.

Last February, a group of us decided to uncover the levels of stress experienced by second year students, with a view to developing the support services.

We were extremely encouraged by the response which seemed to reflect a growing concern amongst our colleagues for their own and each other's emotional wellbeing.

Although we half-expected our study to uncover a real need for more support, we were still quite shocked by some of our findings.

Nearly two thirds of the year found life at medical school extremely or moderately stressful.

Well over one third experienced feelings of despair and depression, and most worrying of all, was that nearly 10 per cent of them had seriously contemplated suicide.

But it wasn't just the minority that felt the need for more help. When asked the question: 'Is the level of support sufficient?'—97% said No.

So what kind of support would be most welcomed?

For work related problems, the personal tutor system was found to be most helpful.

However, for emotional problems, it seemed that a more independent support network was needed. One that didn't involve anyone directly related to the medical school; one that provided a place of refuge where any problem, no matter how delicate or sensitive, could be discussed openly with absolutely no fear of repercussion.

And to meet this important need, UMDS have now set up an independant Counselling Service as part of the new student occupational health facility.

Two counsellors have been appointed; Paul Porlin and Diana Bass.

They both trained at London University and have wide ranging experience, which includes working with students.

At the moment the counselling service is based on floor one of Riddell House on the St Thomas' site. However, Paul and Diana will also soon have a base at Guy's.

To make an appointment phone x3141 and, if the counsellors are not there leave a message on their answerphone.

The opening hours are yet to be finalised; mainly because Paul and Diana are keen to ensure that they fit in with timetables. So, within reason, appointment times will be flexible.

If you can't wait for an appointment and need to talk to someone immediately, you should go up to Occupational Health and they will provide on-the-spot support, and arrange for you to see either Paul or Diana if you wish.

Perhaps the most important aspect of the service is its complete confidentiality. No-one outside the consultation need ever know.

Both Paul and Diana appreciate the unique stresses of life at medical school, and the immense burden that we all place upon ourselves of feeling we should be able to cope alone.

They see their role as one of listening, supporting and helping us find new solutions to old problems. They are more than happy to talk about anything at all that you can't cope with, no matter how embarrassing it may seem.

And their main message is: 'Don't leave it too late.' Its far better to tackle a problem at an early stage than wait until its affecting your work, and more importantly, your health.

But, as in all areas of medicine today, the future needs to address prevention too, and although it may be impossible to eradicate the major causes of stress at medical school, it may be possible to help us find better ways of coping with them.

Academic Computer Unit

It is typically when faced with the prospect of writing up a BSc that students discover the existence of the Academic Computer Unit on the seventeenth floor of the tower. Is there any point knowing about it before, or if you're not doing a BSc—well I leave that up to the individual to decide.

The Unit has on offer IBM compatible PC's as well as three Apple Macs (soon to be joined by a fourth). A wide range of programs are available from wordprocessing to graph drawing, desktop publishing to statistics so no matter what you want to do, it should be possible; you can even make tea, but for that you need to use the kettle! High quality print outs on the laser printers, and there is also the facility for colour printing using the Macs. There is a nominal registration fee of £5 for the use of the Macs, which incidentally also need to be booked in advance. Electronic mail is also available to all the academic institutions nationwide via the Joint Academic NETwork (JANET)—you do of course need to know the electronic 'addresses' of anyone you want to send messages to.

Opening hours are from 9–5 and during most of this time Mike is on hand to offer free and copious advice to coax you past the milestones to computer literacy. There is also another side to the centre; you can buy/order computers, programs and consumables (disks etc.—not food!) through them. A few new ideas that may soon be introduced are a list of second hand equipment and beginners courses covering broad topics such as wordprocessing or desktop publishing. If you're interested in either of these two potential services, then get in touch with Pete Tedder on x4836 so that he can gauge demand.

Summer Term

Welcome back from your Easter breaks. I hope that you have had a good time skiing, sleeping and thinking very hard about this summer's exams.

Many students at Guys' have been on tour. I do hope that wherever in Europe and further afield you toured that the good name of this Hospital was not too tarnished. A special mention must be made of the Ladies Hockey Club who did their best in improving Anglo-Dutch relations.

Student Union elections are upon us. The posts of President and Vice-President are balloted for on the 20 and 21 May. Nominations must have been received by the 16 May. Start campaigning now so as to not be disappointed. All other posts are up for grabs one week later.

My thanks for their year's work go especially to Jim Lewis, Paul Frisby, Andy Klein and Gordon Kooimans. I feel that this year has been a successful one in which much has been achieved.

This term is also a very special one. Charities Week occurred at the end of April. There is also the Summer Festival and the Summer Ball at Cobham.

My best wishes to all of you this term and I hope you all get the results in your exams which you deserve. Most of all—enjoy the summer term.

God Bless.

R Russell
Guy's President

Dental Society Meeting

'Into the Naughty Nineties'—Norman Whitehouse, Secretary of the BDA—a menu to well and truly whet the appetite and a gathering of 130 hungry for information.

Professor Rowe introduced Mr Whitehouse who qualified at Leeds (yes, there is a dental school there) in 1961. Prior to taking up his post at Wimpole Street in 1986 he worked in Cardiff at the Dental Hospital and as an Area Dental Officer.

Mr Whitehouse first posed the question, *why change the old contract which has been in place since 1948?* He felt it no longer reflected what most dentists are doing, as the emphasis changed from treatment to care through prevention.

Our patients had been made aware of instances of abuse and over prescription by such media colossi as Esther Rantzen and Schanschieff and the infamous Drilling for Gold.

What changes were made? Kenneth Clarke, Health Secretary at the time, was firmly committed to capitation. He advocated a scheme for children in which the vast majority of payment was not treatment dependent. So we were to be rewarded for keeping children caries free.

For adults 90% of the fee is item of service dependent and 10% for a continuing care commitment. In return for this however three additional services must be provided. Firstly, written estimates—which in 80% of cases Mr Whitehouse thought were a waste of time. Secondly, free replacement of any treatment that goes wrong in the first year; and thirdly, a reasonable level of emergency cover. He felt that the second and third services were provided by most dentists anyway.

So where has the new contract gone wrong? It is too bureaucratic, there is inherent professional resistance to change and it is underfunded.

With regard to the thorny subject of the referendum Mr Whitehouse felt there should not have been one.

He then turned his attention to our position in the year 2000. The Government want maximum level of control and our patients will demand ever higher levels of health care.

The system will, irrespective of the party in power, be gradually eroded for those who can pay and the definition for those who don't will be changed. Will the public tolerate a move out of the NHS? At varying rates—yes, and private health care plans will be increasingly popular. It will continue to be necessary however to protect the interests of those who are severely financially compromised.

Mr Whitehouse said the association was managing changes at a pace that dentists can accept and felt that the new contract had bought the profession time. There was no going back on the contract (yes, it would last longer than the poll tax) and there would be less bureaucracy and an increase in funding.

In conclusion, Mr Whitehouse was concerned as to the decline in student membership and asked for reasons.

A low media profile, lack of communication and moderate 'swimming with the tide' approach were reasons cited. He was keen to remedy the situation.

Mr Paul Copson thanked Mr Whitehouse for a thought provoking and enjoyable evening.

Mark Phillips
Department of Prosthetic Dentistry

Prepare For PREPP

PREPP—Post-Registration Education & Practice Project, is a proposal by the UKCC to 'shape the future pattern of education and practice for all nurses, midwives and health visitors'. Until a few years ago, in common with Nurse Gladys Emmanuelle, all SRNs RMNs etc., once qualified were on the Register until death or malpractice did them part. Now we have become RGNs etc., and need to re-register plus a fee for the privilege, every three years.This has eliminated everyone over seventy for starters, and initially annoyed some nurses who did not relish free payment triennially when they had already, as they assumed, paid to register for life. All this is past history, and now there are sweeping new proposals, including need for evidence of continuing professional learning, before a nurse will be allowed to re-register.

This sort of 'MOT' for nurses serves to protect the public, patients and clients, primarily; advance in the technology we all use gives additional impetus for keeping up to date. Midwives have put their heads in front; for a long time they have been required to attend regular refresher courses, to maintain the letters SCM after their names.

Midwives practise within a precise specialized area, whereas nurses practise in widely diverse fields. With my predilection for predictions, continuing readers of this column will note my earlier hope for just such a proposal now offered by the UKCC. There are a number of other topics addressed by PREPP, and I would commend a study of these to readers. But briefly, one central concern for those nurses currently in practice is the recommendation that a minimum of five appropriate study days each three years be undertaken.

Those of us who have sat other non-vocational academic exams know how soon we lose knowledge we do not practise; therefore it may be argued by those who work in places such as Guy's that they already fulfill practical requirements of this nature—and although PREPP expects to make this a statutory obligation—some may question its usefulness. Every nurse will be responsible for their own 'profile', detailing evidence of training and experience. The maintenance of competence and professional knowledge has a dual commitment: for the practitioner and the employer.

This is good news, because some nurses, particularly those in lower paid grades, have expressed anxiety about the cost of keeping up to date. Employers will be responsible for providing facilities both in terms of time and money, to see that PREPP happens. The practitioner will have responsibility for ensuring attendance at courses or study days.

Other proposals relate to support for newly qualified nurses. I wrote at some length on the staff nurse development course at Guy's last year. Presumably this will be somewhat akin to PREPP's suggestions for the newly registered.

Another significant change will involve those who have not practised for more than five years but wish to return. PREPP supports a 'return to practise programme'. This is surely long overdue. The nursing profession is still predominantly female, and as it is still women who give birth and often give up work in the profession to care for young offspring, there are frequent gaps of over five years in the careers of many nurses. Orientation programmes have been introduced at some hospitals and in the community to ease their return, but PREPP will make this mandatory. Nevertheless a recent survey

shows that more women now return to paid work within nine months of giving birth.

There are various other changes which the PREPP Report hopes to enact. But those affecting most nurses I have outlined in précis. I can only emphasize how brief an overview I have given in the space at my disposal, but the UKCC is still awaiting nurses comments. Write to them now and let them know what you think!

Denis Cobell

Guardian Angels

In May 1989 I wrote about the Guardian Angel of St Olaves'. One day I returned to visit her only to find her missing. Now it is our turn to go missing. It seems that St Olave's has been sold at last. The old Hospital building has to have the uncontained asbestos removed and the ruins are to be demonlished. Before the demolition takes place, the physiotherapy department has to be the first casualty. In order to maintain access to St Olaves' House (the Nursing Home) and not disturb the trees in the garden area (rightly these trees have a protection order on them) our prefabricated building has to be unfabricated.

The outpatient physiotherapy service has continued unbroken since the closure of St Olave's Hospital in 1983. Three physiotherapists work there in the mornings and return to Guy's for the afternoon session. They are supported by a Helper who is a highly valued person, who keeps the whole show running. Approximately 96% of the referrals are directly from local GPs, the other 4% or so being SE16 residents who are referred by orthopaedic and rheumatology consultants at Guy's.

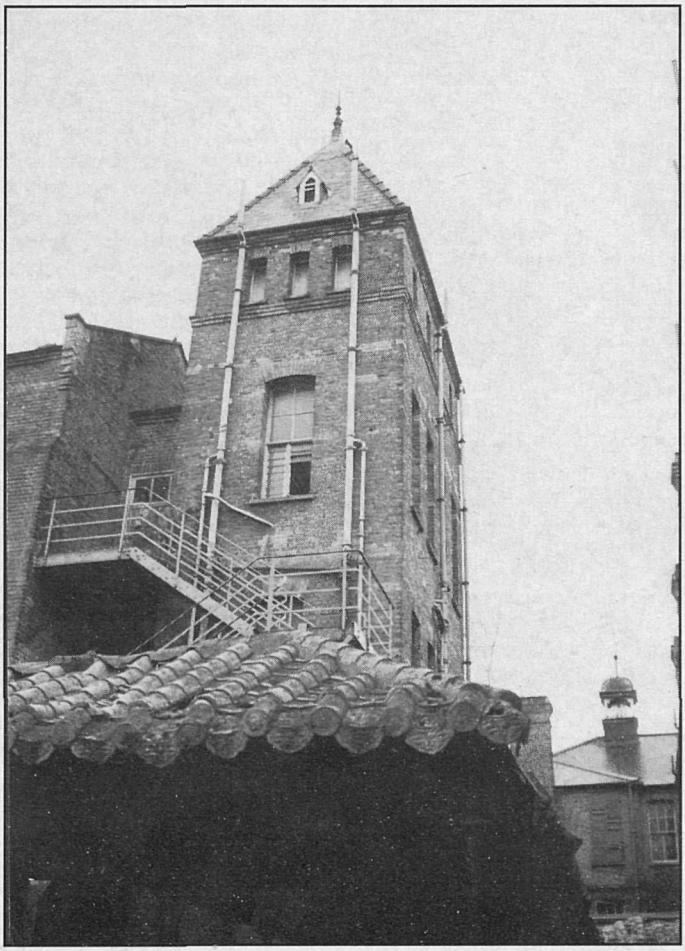
This Department is very much part of the local community and the Rotherhithe patients are the perfect patients. They rarely DNA. If unable to attend they will always telephone. Usually they arrive early for an appointment, knowing that understanding neighbours will be around to share a conversation. And so, not only do they receive physical therapy, but also general friendship and support from the community.

As our last day of business is 17 May we do not have time to find alternative local accommodation. We will be trying to relocate within the locality in some form but this will need more than the six weeks notice that we have been given. Meanwhile the service will have to move into Guy's. That will be the very tight squeeze of the proverbial sardine as we now only have one Treatment Room. The others have gradually been taken over with and without our agreement. And so once again it is the patients who suffer.

They will have to travel to Guy's and when they get here we will have to transform them into sardines.This in itself could, of course, be therapeutic. The aroma therapists may be dismayed to discover that the physiotherapists are still skilled at massage with oil.

Hopefully we will be able to transfer suitably, so that the service which is so enjoyed by the physiotherapists and the Rotherhithe patients alike will be able to continue without hitch.

Diana Innocenti



Rugby Club

Guy's RFC Reunion Weekend (March 16/17)

The weekend began well. The first fifteen beat a visiting US Portsmouth side by a handsome margin. England were victors in an international of skill and sportsmanship. So, it was in good humour that the diners assembled in the Keats Restaurant. A good meal was followed by speeches from Richard Docker, Jeremy Worth and Terry Gibson. The guests were Mr and Mrs Eric Dann. Once again, the band ranged the generations ending with a popular Scottish reel. Or was it an Irish jig? Once unravelled from the chandelier, Richard Docker led some fine choral renditions. Bob Dyer's singing reminiscent of a fading Frank Sinatra, suffered from a slight incoherence. Pat Crush gave a theatrical recitation and before the evening finally collapsed, there were many more solo efforts of varying quality.

Around lunchtime the next day, the party revived with the congregation of players friends and families. It was a fine day and after some horse trading and shady dealing, both games proceeded.

Past 1st XV v. Present HOPs
17 March 1991. Past won 10–6

After a very successful and distinctly liquid celebratory dinner the night before, both sides took to the field a little light-headed and with a mixture of enthusiasm, trepidation and a profound gratitude that they were not Bob Dyer.

A comprehensive warm up in the changing room had got the old hands of the Past team in the right frame of mind. This consisted of everyone who had not seen Mike Seare for a little while remarking how much weight one can put on in a little while and the collective advancement of the null hypothesis that size of belly is not inversely related to size of genitalia.

Aroused by captain Nigel Poole's customary emotionally charged pre-match speech and so fired by the knowledge that Nigel was thankful for everyone turning up and it was nice to see some old faces again, the Past team looked particularly fearsome, an impression considerably helped by the fact that they had the only person on the pitch over six feet.

Unfortunately, both sides had been affected by last minute absentees. The Present team were without Jim Boothroyd and Bill Murphy which meant that Tony Rose, flying in the face of tradition, would actually win some line-out ball; for the Past team, Charlie Beardmore had a last minute call-up from God and had gone to seek absolution for his sins (the rugby club, several women, a sheep and a lizard called Larry have asked for two hundred other offences to be taken into account).

The Present team kicked off and were immediately served notice by the skill of the opposition and the size of the task that faced them. Graham Meharg, who with a deft sleight of hand caught the ball, dropped it, caught it again and then put in a towering kick along the touchline which pushed the opposition back three feet, if not a yard. The forward's heads visibly sunk.

However, Tony Rose won the ball from the ensuing line-out, a feat accomplished

by the simple act of lifting his arm up, and when Nigel Poole shocked the crowd and his inside centre by actually passing to his backs, we knew we were in for a fast-flowing, running game of rugby. And, in all honesty, that's what it turned out to be. The Past team were especially keen to run the ball from positions, but both teams contributed to what was a very entertaining festival game of rugby.

The Present team just had the edge in the early exchanges, the team's cohesion and the benefit of recent Hospital's Cup preparation particularly evident in the rucking of their forwards. The half-backs, John Costello, who was especially good around the fringes, and Neil Davis, played with assurance and not a little aplomb, but good defence by the Past midfield meant that for all their panache they never actually looked like scoring. This was further underlined after a move by the Present team's backs had broken down under pressure in the middle of the pitch and Nigel Poole chipped ahead to the left wing. Graham Bevan sensibly hacked on and, after a brief interlude for shock suffered on seeing the ball go exactly where he'd intended, dived over in the corner to score. Andy Hall managed to shovel over the conversion from the touchline with a kick which made up for in height what it lacked in distance.

Unfortunately, at this point Charlie Popplewell's body finally succumbed to the lifetime of clean-living and vegetarianism to which it's been subjected and he had to leave the pitch and, it is rumoured, the front-row forever. But the Past were lucky enough to be able to wave down a passing time-machine and commandeer a young classical composer from the Hapsburg wurts of eighteenth century Austro-Hungary to play flanker. Get your hair cut Ady!

The rest of the first half was evenly contested with the Past team gradually adapting to each other's style of play and putting together some promising moves. The Past's back-row, in which Graham Meharg played with tremendous skill and enthusiasm and Jamie Barwell played with enthusiasm, were constantly in support of the midfield and made great inroads down the middle of the pitch. However, persistent infringements meant that Neil Davis was able to kick two penalties for the Present team and level the score.

The second half saw the resumption and further development of several interesting personal contests.

Mike Seare, playing with great poise, had a constant tussle in the scrum with the Grand Oracle, Edson Cheat, who was as inscrutable as ever. It was a close personal battle but at the end of the day honours were pretty even. (This, of course, depends upon your definition of 'even' which, it must be said, was Mike's way of describing events. Some students of semantics think it may be a bastardisation of the phrase 'got stuffed').

The Llewelly-brothers, Ross and Wayne, kept up their close-run contest with the referee, advising him in a brusque, albeit melodic, tone as to ways he could improve his decision making and matters relating to the odd circumstances surrounding his conception. In doing so, they managed to wrest the 'Biggest Cob of the Year' award away from Alan Jones, who simply smiled benignly in the centre, for the first time since Kevin Shuker gave up his boxing career. Everyone was pleased but not in the least surprised that the award will be staying in Wales.

Phil Cunnington had an excellent game scavenging on the floor for any loose ball and in one memorable instant leaping almost six inches to take a two handed

Above: Present 1st XV
Below: Past 1st XV

catch in the line-out, much to the chagrin and profound embarrassment of six-footer Meharg who has not spoken to him since. However, as the game wore on it became obvious that Phil was emotionally drained from playing alongside his father, whom we all, wife included, see too little of nowadays.

As the game entered the final quarter, the Past began to exert consistent pressure on the Present team's backs and were finally rewarded with a try in the left hand corner by scrum-half John Murphy, who had an excellent all-round game, after the ball had been spun wide to both touch-lines and admirably kept alive by wings Paul Scanlan and Graham Bevan. The conversion went wide.

The Present team tried to regain the ascendency in the ten minutes remaining with Neil Davis especially showing some good penetration and so enjoying success so lacking in his private life at the moment. However, the Past defence remained effective if somewhat shaky and Pat Crush and Steve Lewis were both brought down by excellent cover tackles when a score seemed likely.

When the final whistle went the crowd stood and applauded a highly exciting and entertaining game of rugby, the Past team celebrated its first win for some years and Lüdwig Van Watts vowed to write a symphony in honour of our victory.

The Present team, magnanimous in defeat, clapped the Past team off and sulked for the rest of the night.

Teams:

Present: Matt Rose; Pat Crush; Steve Lewis; Guy Selmon: Dan Rose; Neil Davies, John Costello; Edson Cheat; George Tsolakides; Ross Llewellyn; Andy Skyrme; Phil Cunnington; Jeremy Worth; Wayne Llewellyn.

Past: Andy Hall; Graham Bevan; Tony Wilson; Ian Wright; (rep. Alan Jones); Adrian Watts; Nigel Poole; John Murphy; Charles Popplewell (rep. Paul Scanlan); Roy Dixon; Mike Seare; Tony Rose; John Brazier; Ian Francis; Jamie Barwell; Graham Meharg.

Tony Wilson

Past 2nd XV v Present Present won 12–0

The game followed a characteristic pattern with the forwards gaining rough parity and the younger Present backs making more ground. It was also as fiercely contested as usual with several flurries of vigorous exchanges between the packs. The Past side tired sooner. The energetic Pugh made life difficult for Howell in the front row, White, Lewis and Zangouras took on the rest. Rosell and Willings made some fine breaks from the back of the scrum and Coombes posed a constant threat with his unpredictable, darting forays. Occasionally the ball moved down the line to Howarth-Graham, Linney and Vesey but the Past defence was effective enough. Both sides came close to a score in the first half and Danford, missed a penalty kick. It was White who forced the first points when a ruck forced its way to the Past line and collapsed at the centre. Coombes converted.

The second half was no less fierce. Koffman kicked with increasing quile and the back row of Bowskill, Hogan and Ferrings put increasing pressure on the Present players. Despite territorial advantage the Past side could not score. Fewings went off with a neck injury and was replaced by the newly arrived Martin. Inevitably the speedier and younger Present backs attacked with increasing effect. Their efforts were rewarded when after several swift runs, Schaeffer eventually scored in the corner. Coombes converted from the touchline.

The closing minutes were no less intense and the wise intervention of Prof Challacombe allowed the game to finish amicably.

Teams:

Present: C Pugh, S Russell, T Huseyin, N White, D Zangouras, J Lewis, P Rosell, N Willings, J Coombes, P Howarth-Graham, A Linney, M Vesey, W Schaeffer, G Miller, R Dyer, P Barwell.

Past: C Howell, T Gibson, W Sturzaker, A Slade, J Conchie, R Bowskill, P Fewings, M Martin, W Hogan, G Koffman, A Porter, D Guppy, T Lloyd, K Underwood, D Quick, M Danford.

Guy's 5th XV v Bexley 4th XV.

We arrived at Bexley with twelve players and the opposition very kindly lent us one of theirs. Their Captain offered to do a bit of a swap around at half time and things got a bit 'silly'. However I did not have the heart to tell him we had acquired two secret weapons in the form of the infamous Dipper and Andy Linney.

As the two walked onto the pitch we were all fairly confident of winning. I lost the toss as usual, but the pitch and weather conditions, although a little warm, were good (apart from the river being three inches from the dead ball line which delayed play a couple of times).

Paul Barwell scored one try, Dipper scored three, though after the second the opposition realised that they would be better off attempting to stop the twelve twenty five to Aberdeen. I was told later that there were a couple of train spotters on the team.

In a great flourish of energy, pursued by disheartened and exhausted opposition players, Paul McEnerney, in the dying minutes of the game, scored our last try of the season, some of us even watched it. This was the climax of a very enjoyable season.

Team:

D Norgate, D Ferns, T Hussain, H Evans, H Duncan, M Peters, J Barwell, A Linney, P Hargrave-Graham, P Barwell, M Wagstaff, P McEnerney.

Harry Evans

Netball Club

Jamaican Tour

Jamaica—it was a dream. Nobody believed we would ever get there. After all we had to raise £1,800! It wasn't 'A Piece of Cake' (but we couldn't have done it without them). After sponsored walks, raffles, MPS, MDU and MSS sponsorship, slashed airfares (because of the Gulf War) and 'two fly for the price of one' tickets (courtesy of the *Daily Mail*) we made it. All of a sudden eight netballers were in the air at once flying with the world's favourite airline off to Jamaayka.

Following a number of trans-Atlantic telephone conversations our itinerary was organised and matches planned. The President and Vice-President of the Jamaican Netball Association were to put up four team players and the remaining four were to stay with two other members of the Jamaican netball team. Our days commenced with training at 6.30 am at the National Stadium in Kingston and matches were played in the cool of the evening—a mere 85°C. We were slaughtered by the Jamaican National side ranked 5th in the world but had fun participating in a tournament against seven club teams from in and around Kingston and a number of other matches.

The Jamaicans were a warm and friendly crowd whose hospitality was legendary. They provided us with breakfast and incredible evening meals of aki and swordfish, goat, oxtail, parrot fish, and egg nog washed down with Jamaican rum. The team hired two cars which enabled us to explore this beautiful tropical island, pitting our wits against the Jamaican motorists. We visited the Blue Lagoon, rafted down the Rio Grande and clambered up the Dunn waterfalls. All in all it was a memorable ten days and I would like to congratulate all club members for their fund raising efforts and would hope that our success will encourage other clubs to travel further afield on their team tours in the future.

Clare Walford

Above: Gita Auplish; Alison Currie; Rachel Hepher; Julia Jefferson; Nicola McDonald; Katie Powell; Kate Scanlan; Clare Walford.

Dentist Wanted

Tolworth, Surrey. We need a dentist to start a third surgery, being built as I write. We are a mixed NHS/Private practice. Friendly staff. Full clinical freedom.We do paperwork for you. Principal helpful and (!) understanding. Sense of humour essential. Telephone Chris May (day=(081) 399 1526, eves=(081) 337 9650).

Death

DAWE, Ernest Ben. He entered Guy's in 1936 and died 11 February, 1991.

Change of Address

Dr John W McLean, OBE DSc
10 Wildwood Rd,
London
NW11 6TB.

Dr P R Montgomery
11 St Clement St
Winchester
Hampshire
SO23 9HH.

E Tweddle
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Petersfield
Hants
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125 year lease; £89,950 o.n.o.

Can be seen during the day or evening; and weekends by appointment.

Telephone: 071 403 3966 (up to 7.00pm generally), or 081 464 1195 (later/weekends).

Congratulations

Congratulations to Garfield Pearce on his 80th birthday 12.5.91 from his family and friends.

THE MEDICAL DEFENCE UNION

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GUY'S HOSPITAL GAZETTE
June/July 1991

THE WILLS LIBRARY
28 JUN 1991
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- Prof Gosling — the friendliest professor in Guy's
- Guy's As a Trust — an interview with a potential purchaser
- Bungy Jumping — it could only happen in Australia

Mrs Margaret Campbell, vice-chairman of the Friend's of Guy's Hospital receiving a cheque, being the proceeds from the 'Dolphin Pool' at Surrey Quays Shopping Centre on 11 April, from Mr Peter Brooks, the centre manager.

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Volume 106 Number 2413 June/July 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

Unbelievable. There has been a complete revision of the pre-clinical and clinical teaching curricula, and the proposals seem excellent. The BMS course is actually going to become clinically relevant and is to be taught on a system-based approach; this presumably means that, for example, the physiology, biochemistry, anatomy and pharmacology of the respiratory system will all be taught in the same term. Extraordinary.

Furthermore the course will be designed to encourage 'effective learning rather than factual recall'; this change strikes at the very core of the present BMS course and, who knows, may be the death knell of that much-maligned memory test known as the Krebs' Cycle.

The clinical curriculum is almost unrecognisable after its overhaul. There is going to be more choice and a greater emphasis on the importance of good doctor-patient communication. A particularly interesting development is that the final year will become 'a flexible period planned by the student to include an elective of up to twelve weeks, regional attachments, specilities not already covered, A+E, and shadow house officer posts'. This should allow students to hone their practical skills and also prepare them for the rigours of the pre-registration year. There is even to be a diary of experience to monitor the areas covered, and the final exam will be integrated and involve physicians, surgeons, clinical pharmacologists and pathologists examining together.

These proposals are subject to approval both within UMDS and at the University, but it is hoped the new course will start in 1992.

There is only one problem—what are we going to whinge about in future Passims?

Dentists As Doctors

Dear Sir,

I read with interest and some amusement Mr Lyndon Cabot's article 'Should Dentists assume the title Doctor?'.

The word 'doctor' can be regarded as carrying three meanings: first it is an historic title conferred on those considered to be learned. (*Doctus*=learned (Lat.)) e.g. physicians, lawyers and churchmen. Since nowadays most people are literate and numerate, this use of the word to distinguish the educated from *hoi polloi* is obsolete.

Secondly, it is an academic title held by those with doctorates.

Thirdly, it is a job description. In common parlance 'doctor' is synonymous with 'medical practitioner', and it is for this reason alone that the title is retained in this context.

How appropriate then would be the dentist's assumption of the title?

First; are dentists (or medical practitioners for that matter) learned? Some possibly, but no more so than lawyers, psychologists, engineers or hospital administrators (?), who languish in the humility of the title Mr or Mrs and who presumably don't lose much sleep over it.

Secondly; are dentists academics? Some undoubtedly, and those holding doctorates may accordingly emboss their luggage with impunity if they so desire.

Thirdly; can the word be used by dentists as a job description? Clearly not.

Having dealt with those points, let's examine some of the less watertight ones mentioned in Mr Cabot's article.

The conclusion that the title is justified because it accords the greater confidence and respect of patients is clearly a *non sequitur*, since presumably the titles of Lord Justice, The Rt Rev or His Holiness would have the same effect, but would of course be similarly invalid.

It is difficult to understand why the dental practitioner should be bothered by whatever title he is addressed. Could it be that one's titular aspirations are inversely proportional to one's intrinsic worth? I doubt whether Mr Patrick Steptoe, for example, was smitten with such inferiority paranoia over his form of address. Indeed one imagines he was more concerned with his test-tube than with his title.

Let's not shy from calling a spade a spade, no matter how exalted we consider it to be.

Yours faithfully,

ANDREW FARMERY
Dept of Thoracic Medicine
Guy's

Theft At Guy's

Dear Sir,

As one of the last generation of Guy's men I feel I must write to you and your readers to tell you that despite all the recent upheavals in the Medical School and the Hospital one old Guy's tradition does still exist. I am, of course, referring to the 'noble art' of stealing from the clinical locker room.

After returning from a lengthy vacation (or vocation), my M2/S2 course, I ventured down to the locker room to pick up my white coat. Imagine my delight on finding that my locker had been broken into and everything stolen; my stethoscope, my pens, the lot, excluding John Rees' excellent *Medical Catechism*; why this was not stolen I do not know! On entering the Spit to tell the rest of my firm the good news I

was told that two of them, making three of out of four, had been similarly cleaned out.

I was wondering if the powers-that-be in the Medical School would put the matter of locker room theft under review and do what they have done to all other great Guy's traditions; stamp it out!

Yours faithfully,

STEVEN PRYKE
Boland House

Miss D M Smith

Dear Sir,

Further to her obituary in the *Gazette* of March 1991, it may be of interest to your readers that the late Dr R E Smith, the distinguished physician from Rugby, and a Guy's man, was in fact Miss Smith's brother. Two of her nephews, Dr Paul Jackson and myself, also qualified at Guy's. After a Service of Thanksgiving at Horsham Parish Church, a Memorial Fund was opened in her memory which will partly benefit the Nurses Benevolent Fund. Donations may be sent to: Account No S1103989 (J E Brown/DMS) Barclays Bank, 75 Connaught Avenue, Frinton-on-Sea, Essex CO13 9PY. Incidentally, I can assure you that my aunt would have thoroughly approved of your journal returning to the A5 format!

Yours faithfully,

JOHN BROWN
Westfield Barn House
North Lane
Weston-on-the-Green
Oxon

Good Old Gaz

Dear Sir,

It is with great pleasure that I received the last two copies of the *Gazette*. We are all very keen to carp and criticise when matters go awry and are not to our liking. May I, therefore, through your journal proffer my congratulations on the front cover which depicts the 'trade mark' of the late Thomas Guy. A coat of arms is after all a rather elaborate form of trade mark! And *mirabile dictu* as a bonus, the old familiar format, pocketable for the gentlemen and handbaggable for the ladies, is restored to us.

A hundred thousand thanks to you as the Editor and to your team.

Yours faithfully,

R INNES MUIR
Redlands
Hardingham St
Hingham
Norfolk NRJ 4JB

Closure of Teaching Hospitals

The government has said that its plans to create an internal market in the NHS may lead to closure of some of London's teaching hospitals. The Junior Health Minister, Stephen Dorrell, said that 'hospitals don't exist to train doctors or conduct research. While I don't dispute research and training, they must fit in around the provision of hospital services which suit the patient'.

The BMA deputy secretary, Dr Michael Lowe, warned that it was unsatisfactory for ministers to leave training and research to the market. 'The suggestion that patients must decide where training would be is extraordinarily unsatisfactory. Most training hospitals are under-used because they are under-funded'.

Guy's Hospital East Anglian Society

On Saturday 6 April the above Society met at the Ipswich Moat House under the Presidency of Mr Hujohn Ripman. 85 members and partners heard the Guest of Honour, Prof Tim Clark speak of Guy's and the 'NHS reforms' and the establishment of the United Medical and Dental Schools of Guy's and St Thomas'. We were honoured that he and Mrs Clark could join us to make a memorable evening.

It was suggested that there might be a combined East Anglian Dinner with St Thomas' in the future. The Hon Secretary is investigating the feasibility of this venture.

The next Dinner will be held in Norwich in the spring of 1993.

Hospital Violence

A survey reveals that almost 90 per cent of health service workers are worried about violence at work. Verbal abuse and threats are so common that many employees regard them as part of the job.

NUPE, the union which carried out the survey, wants improved security at hospitals, and training on how to deal with awkward members of the public. At present, only 3 per cent of hospitals offer special training to all staff, and nearly half give no training at all.

Brook Hospital Remains Open

Greenwich Health Authority has promised not to close the Brook Hospital in south east London, saying it will be in use for several years to come. But campaigners against its threatened closure fear the decision will be shortlived because of cash constraints.

Eye Disease

It is estimated that nearly half a million people, many of them elderly, are unknowingly suffering from eye disease, undetected because they are reluctant to pay for an eye test since the free test was abolished two years ago. Conditions such as glaucoma and cataracts, which may ultimately cause permanent visual defects and blindness, are not being picked up. Figures show that 13 million people per year had eye tests when they were free, compared with 10.5 million now.

Trafford Appeal Is Launched

The Prime Minister, Mr John Major, and his predecessor, Mrs Margaret Thatcher, were among the guests at the House of Lords on 20 March to launch the Trafford Appeal.

The Appeal aims to raise at least £2 million for the Trafford Centre for Medical Research at the University of Sussex.

The Centre is named after the late Lord Trafford. Lord Trafford, who qualified at Guy's in 1957, and went on to a distinguished career in medicine and politics, died in 1989. The Appeal was the idea of his wife, Lady Helen Trafford, herself a former Guy's nurse.

Further information can be obtained from the Trafford Appeal Office, University of Sussex, Falmer, Brighton, Sussex.

Move Patients to French Hospitals

French doctors and lawyers are forging ahead with plans to persuade GPs to send patients to France for treatment.

GPs from the south of England are due to go to France, next month, to finalise agreements.

Lawyer Philip Jenkinson, negotiating for the Ducheme Hospital, in Boulogne, says the hospital wants to attract business from all GPs: 'Fund holders can choose where to send patients. Non-fund holders can put pressure on health authorities to pay for treatment in France.'

He insists any attempts to prevent patients travelling to France for treatment would contravene the Treaty of Rome.

Below: (l to r) Lord McColl, Lady Helen Trafford, Professor Maurice Lessof and Sir Terence English at the launch of the Trafford Appeal

Cuts in Juniors' Hours?

The projected cuts in the hours for junior doctors by 1995, as reported in the last *Gazette*, is looking a little more shaky. Doubts among consultants, concerned with being left without adequate staff, have proved a stumbling block. They are worried by the time course in which the changes are proposed, and talks are continuing.

Up to 40% Pay Rise for GPs

Family doctors' incomes have increased by up to 40 per cent in the first year of a contract which was strongly opposed by the medical profession, according to a survey by the agencies that pay GPs. It has been calculated that the average GP will earn £34,700 from the NHS this year.

Increase In Medical Research Spending

Spending on medical research and development in the NHS will nearly double in the next five years to £390 million. Six to ten national priorities for research will be drawn up in the next few months. Research will mainly be aimed at reducing deaths and preventing expensive hospital care.

Volunteer's Conference

The LSE's Centre for Voluntary Organisation has organised a two day course (June 18–19) for the increasing number of people in the statutory sector who work in some way with voluntary agencies. *Understanding Voluntary Organisations* will look at how decisions are taken in voluntary agencies; the pressures confronting their senior staff; the role of management committees; how change takes place; and how voluntary organisations meet demands for accountability.

Details from: The Course Secretary, Centre for Voluntary Organisation, LSE, Houghton Street, London WC2A 2AE. Tel: 071 955 7375/7205.

Cannon Street Rail Crash

The image of calm efficiency on the part of the doctors and ancillary staff at the scene of the Cannon Street rail crash was shattered by Linda Hadfield, assistant clinical director in A&E for City and Hackney Health Authority, which covers Bart's.

Apparently, the initial reaction to the emergency call was that it was a joke, she says. Soon a gynaecologist was despatched to the scene, but got lost *en route*. Next, an orthapaedic surgeon tried to commandeer the operation. Neither of them had had recent experience of major incident management.

Philip Harris House

Philip Harris House is now making a real impact on the street and sky lines in St Thomas' Street. Every time you come towards the hospital, particularly from the east or from London Bridge Station, the ever-changing outline of the hospital hits you afresh.

A 'topping-out ceremony' is to be held on 24 July and details of this will become available soon. It is intended to be for as many people as possible, within the bounds of safety, and will involve patients as well as staff.

'Topping-out' a building is a ceremony marking the completion of the highest part of a building. It is a tradition world-wide and dates back to earliest times; there are records of such ceremonies taking place at least 7,000 years ago. Phoenician builders topped-out and there was a recognisable celebration when King Solomon's Temple in Jerusalem was finished in 1005 BC.

The custom still continues that when the last brick, tile or shovelful of concrete is laid an evergreen tree or branch is hoisted to the topmost part of the building.

'A mystical green bough wards off evil spirits and protects future inhabitants' according to the *Oxford Dictionary*. Other sources suggest that the ceremony took the form of hoisting an evergreen bough to the highest point of the building amidst cheers from the workforce and a toast being drunk before the bough was hauled down and burnt. This is said to symbolise the sacrifice of the architect in order to pacify the spirits disturbed by the new building.

Strollerthon Appeal

The mad Nicol family are at it again, raising money for the *One Small Step* appeal. Last year we walked through London as a wedding party with a most unusual 'bride'. Through the generosity of friends and colleagues we raised £900. This year we bring Christmas to central London on June 30 as part of the 'Strollerthon'. Guess who's going to be the fairy? That's right Keith. Ten year old Emily will be an elf with her walking trike as a reindeer, seven year old Jessica will be Rudolf, complete with red nose, and sledge, and of course Father Christmas will be there to supervise things.

We desperately need sponsors, our aim is to raise £1,000 this year. If you feel inspired to sponsor us we can be contacted on (081) 691 2301 or send a cheque made out to 'One Small Step' to our home 23 Rokeby Road, Brockley, SE4 1DE. Your name will then be added to our sponsor form.

We also do other fundraising for the appeal, mainly running a stall at fêtes. We are always looking for helpers, especially those with a vehicle, (the secret to large amounts is lots of people on the stall). One event being planned is a float and stall in Bromley on August bank holiday. If you can help please contact us.

Thankyou in advance for helping us to help build the Gait Analysis Laboratory at Guy's.

Sue, Keith, Emily and **Jessica Nicol**

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BRITISH MEDICAL ASSOCIATION, SOUTH THAMES REGIONAL OFFICE,
VENTURE HOUSE, 15 HIGH STREET, PURLEY, SURREY CR2 2XA.
TELEPHONE: 081-660 5558

Professor Ray Gosling

The quintessential scientist

In September of this year, Professor Ray Gosling will retire from the Chair of Physics Applied to Medicine in the Department of Radiological Sciences. Although this chair was created only 8 years ago Professor Gosling's contribution to medical physics spans a much longer period, covering the ever growing development and expansion of medical physics within clinical medicine.

Professor Gosling arrived at Guy's in 1967 to become a senior lecturer in the department of physics in the Medical School. His task was to establish an intercalated BSc course in Physics Applied to Medicine, in addition to continuing his research. Indeed, these two aspects of his work, teaching and research, have been, and still are, the basic objectives of his career.

The BSc course, now called BSc in Radiological Sciences after the development of this new department in 1984, has become a very popular course, taken up by many 'intercalating' medical students each year. The attraction of the course must surely stem from the opportunity not only to explore the science of medical imaging but also to sample Professor Gosling's fine collection of Bulgarian wines at the traditional departmental promotional evening—from which, incidentally, his annual 'brood of chicks' emerges.

Professor Gosling's love of teaching is long standing. 'I have always enjoyed teaching, particularly the art of simplyfing complex techniques so that they can be taught to and understood by others.' This attitude arises from his own pleasure in using the fundamental principles of physics. 'I don't like to see students becoming bogged down in technical expertise . . . I have received most fun out of using simple science and then combining it with complex technology.'

His initiation into teaching was a challenging period of his career. In 1957 he was offered a position as lecturer in Physics at the University of the West Indies. 'Although apprehensive, I accepted the post and subsequently departed with a handful of equally inexperienced colleagues. On our arrival we discovered that the entire existing staff had been sacked and that we were to be the sole members of the new department of physics.' Although daunting at first, and despite some home-sickness, he chose to stay and the team gradually became established. He began to enjoy his teaching and his new environment; he remained there until 1967 and indeed, it was whilst in the West Indies that he met his wife, Mary.

A youthful Professor Gosling

Notwithstanding the demands of teaching he was still able to find time for research, and he started to discover new fields of interest. He began work in the area of atherogenesis during a sabbatical year at King's College, London, a place that held many memories for him.

For it was at King's that he had obtained his PhD in X-ray diffraction studies of DNA in 1954. This had been a time of great excitement which he recalls vividly. Working under the guidance of Professor John Randall he was able to study biophysics, an area in which he had always been interested. His line of research centered around the reproduction of living cells and Professor Gosling's task was to demonstrate the ordered structure of nucleic acids. Primitive equipment meant that improvisation was required and he recalls spending many exacting hours winding nucleic acid fibres tightly around paper clips so that their X-ray diffraction patterns could be obtained. Under the additional guidance of Maurice Wilkins he was eventually able to demonstrate conclusively the crystallinity of DNA in such fibres; the department then began to concentrate its efforts on this exciting new area of research, and the race to discover the true structure of DNA began. Rosalind Franklin joined the team to help with the X-ray crystallography and as new equipment became available it was possible to study the structure of DNA in much greater detail. It was unfortunate that misunderstandings in the department led to a diffusion of research, for at the same time at Cambridge, Watson and Crick were rapidly uncovering the structure that would lead to their eventual Nobel Prize. It was soon after this period, possibly slightly disillusioned by the politics of research, that he started to move into the area of teaching.

Now however, back at King's for his sabbatical some ten years later, he was able to develop his new line of research into atherogenesis. Advised by his former mentor Randall that, 'for physicists to be accepted by doctors and physiologists their data must be applied to living things'—a maxim that he still holds to strongly—he started work on studying experimentally induced arterial disease in cockerels. He was able to continue this work at Guy's in 1967. It was then that he first became exposed to the difficulties of transferring proven research into everyday clinical application, difficulties that were often due to the seemingly curmudgeonly attitude of those responsible for finance. Perseverance and time, however, led to ever increasing funding becoming available and, in 1976, to one of his major achievements—the establishment of the Ultrasonic Angiology Unit. This Unit has been expanding ever since and is now a major clinical centre for the ultrasonic assessment of vascular disease. Further problems concerning the clinical involvement of the department were greatly alleviated by the development of the Department of Radiological Sciences. This co-operation between clinicians and scientists is something that Professor Gosling has consistently striven to improve.

Professor Gosling has been involved in many areas of research over the years but his main achievements relate to his work in the field of atherogenesis, and to his studies of aortic compliance and of cerebral haemodynamics. It is interesting to note that his three most recent publications still reflect the on-going research in these areas. He was eager to quote a piece of advice from Randall, which he has always taken seriously. 'If you want to do important work, choose an important problem.' Again though, it is often his apparently simplistic approach that has been so successful. His development of the Pulsatility Index to describe a blood flow-velocity wave appears so simple at face value but was, and still is, a major function taken up worldwide in ultrasound and haemodynamic studies.

He was keen to stress the enormous amount he owes to his wife and four sons. 'They keep you with a sense of reality,' he said. Also, he puts a lot of his success down to his BSc and, in particular, his PhD students. 'I have been very lucky with my students in that they have made my work most interesting for me . . . in return I hope that I have infected them with my own excitement for the subject and with the real fun of biophysics.'

Following his retirement, in addition to a long held desire to learn Italian so that he can at last understand his favourite operas, he plans to maintain a strong interest in his work. 'I am looking forward to returning to research at the "pushing a button level". I certainly don't want to be sitting on any more committees.'

We wish him all the best for the future.

PGB

Guy's As A Self-Governing Trust

The South London Market

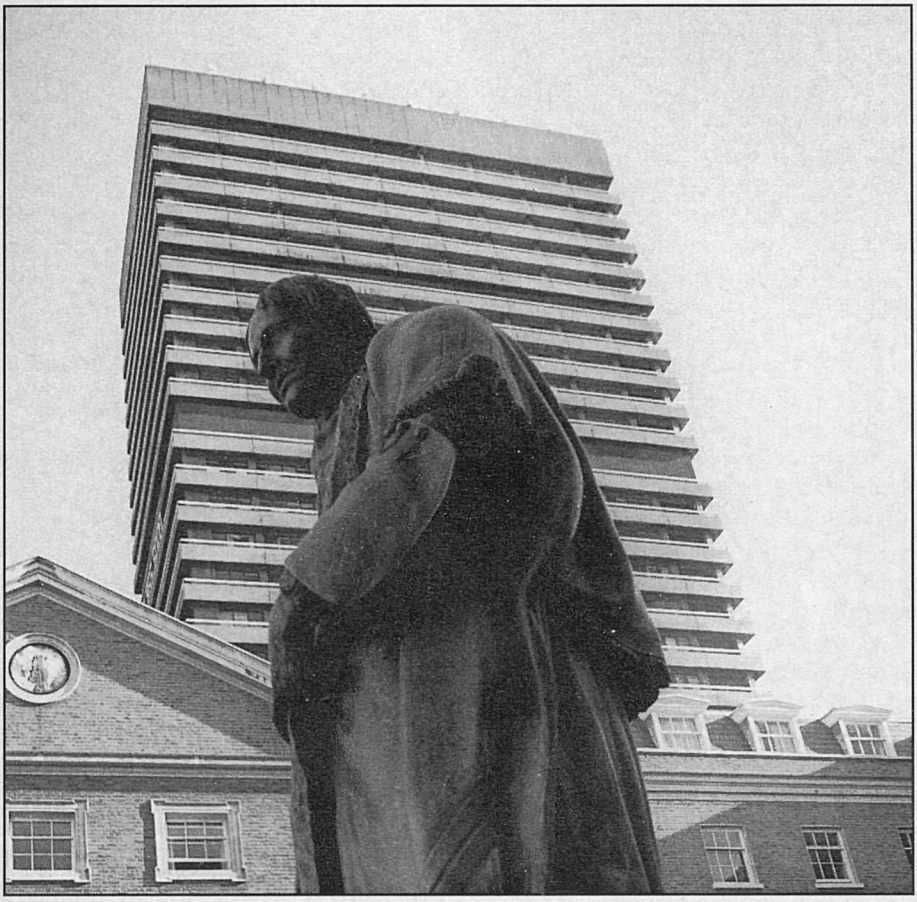
On April 1 Guy's became one of the first 57 hospitals in the country to become a self-governing trust. Since the launch of the white paper in January 1989, Guy's has been closely linked with the changes and has been described by some commentators as a 'flagship hospital' in the new NHS. In fact Guy's will be part of flotilla known as the Guy's and Lewisham Trust which will consist of Guy's and Lewisham Hospitals, together with Lewisham and North Southwark Mental Services.

While a lot of press coverage has concentrated on the formation of self-governing trusts and GP fundholding practices, with attendant predictions of these indpendent units rapidly going bust, the most revolutionary change is the introduction of the 'internal market' into the organisation of the National Health Service. This will separate the providers and purchasers of health care, both aspects previously being, in the main, managed by the District Health Authorities.

In the new system the main function of District Health Authorities will be to draw up contracts for health care in their district, based on the explicit needs of the population that they identify. The hospitals, regardless of whether they are self-governing or not, will have to fulfil the requirements of these contracts as health care providers.

While this system in theory allows for a large amount of flexibility in the provision of health care, this has been attentuated by the government's demand that in the first year patient referral patterns should remain the same as in 1990—the so-called 'smooth take-off'. To further clarify the nature and scope of the changes, and Guy's position in the new system, I talked to a key organiser of the purchasing side of the new system. Dr Sue Atkinson of the Department Of Public Health is a member of Lewisham and North Southwark (LNS) District Health Authority which is now a part of the South East London Commissioning Agency (SELCA).

I asked Dr Atkinson what the benefits are for a purchaser post—April '91. 'The main benefit is to be able to concentrate on working out the local population's specific health needs. Although this was in the background in the old health authorities, the organisation of hospital and community services always took preference. It will enable us to take a more scientific and rational



Guy's Tower and the statue of the Hospital's founder

approach to identifying health needs. For example, the division of LNS into 10 patches has allowed us to take a good look at the distinct needs of these areas, which have different ethnic balances, and varying proportions of elderly and young people.'

What sort of information will be actually be using to gauge health care requirements?

'We'll be using comparative data such as hospital admission figures, demographic data, incidence and prevalence figures and hopefully new sources such as pooled data from the GP screening programme implemented with the new GP

contracts. In the final analysis we'll also have to look at the effectiveness of various services. For example, the widely differing admission rates for some acute problems show that there are a number of different approaches to care, using different balances of hospital and community based services.'

Does this mean that less money will be spent on hospitals as opposed to community-based services?

'This may well happen. To take an example, the hospitalisation rates for stroke victims varies by a factor of three between different areas. This must partly relate to the amount of rehabilitation available in the community, and one could shift resources into this area. Having said that, one has to remember that these types of figures depend on many other factors, such as quality of housing, proportion of elderly people living alone and degree of family support which obviously vary greatly between different parts of the country, but we may well be looking to change the way money is spent.'

How exactly will you work out the relative priorities of treatments such as, say renal dialysis and hip replacements.

'This isn't going to be an easy process. I think it's very important that we do make it clear what our high priorities are and conversely which areas have a low priority. We haven't ever done this in the past and it forces us to be specific about our aims.'

Do you envisage producing a health priority ranking in the same way as they have in Oregon running from the treatment of children with croup at the top of the list through to treatment of urethral prolapse at the bottom?

'The Oregon approach was very interesting because they made a huge effort to find out what the general public's health priorities were and then developed their ranking from that—and it threw up quite a few surprises. I don't see anything as explicit as that happening in the UK in the immediate future. The emphasis is very much on maintaining the *status quo* in the first year and gradually moving to a more sophisticated system, hopefully in a fairly robust way.'

What criteria, apart from number of patients treated and price, will you be using in the contracts?

'The drive towards quality health care is one of the most exciting parts of the new NHS and of contracting. Quality is very strongly emphasised in the model contracts that we've written so far. They detail each stage in a patient's contact with the provider and outline what sort of quality criteria we're interested in, and how we intend to monitor this—although to some extent we depend on the hospitals' own assessment to provide the answers. Initially we'll concentrate on four broad areas: waiting times; health promotion; information for GPs; and medical audit. We also look at these themes at the various stages: outpatient appointments, admissions policy, inpatient treatment, follow-up and so on.'

The Trusts' application for trust status details the number of patients that Guy's sees who are referred from outside the LNS. Do you think that places like Guy's have been historically underfunded for these patients?

'That's a sixty-four thousand dollar question. Funding is now being devolved back from Guy's to the patients' district of origin. Gradually the funding received by these districts will shift to a *per capita* system called weighted capitation. In the first year the districts will have to continue referring those patients and their funds back to Guy's but following that they will be free to refer to where they see fit—which could mean either more or less money being sent to the teaching hospitals. Unfortunately, we in the district do badly out of this shift to weighted capitation, which won't take account of deprivation scores or morbidity data, and the money for the South East London population will be cut by £22 m over 5–6 years.'

During this discussion, you've emphasised the advantages of the District Health Authorities having strategic control over the planning of health provision—what will happen to this if all GP practices opt to become fundholders?

'I have to say that this is fairly unclear at the moment. At the moment the new GP committes, the FHSAs, and the district authorities have a fairly good accord in their approach to commissioning across a wide range of primary and secondary health services. The NHS Act acknowledges the way in which GP's control access to secondary health care provision and seeks to give them more power. The districts would retain some control of health commissioning in this scenario, since at the moment GP fundholders have a limited range of non-emergency services for which they can contract. Having said that I share the concern implicit in your question as to the future of organised allocation of health care.'

Finally, Dr Atkinson, do you think that the efficiency savings generated by the new NHS are going to meet the cost of the bureaucracy necessary to implement it?

'Well, they're going to have to aren't they?

HM

Next week Huw Morris talks to Dr Robin Stott, the first medical director of the Guy's and Lewisham Trust.

Life At Pembury

The move from Guy's

I began a twelve month appointment as RMO at Pembury Infirmary on July 1, 1928. In 1936 I was still there, except I was the SMO and was earning about £900 per year. In those days that was a terrific salary, and my wife and I were able to buy a large detached four-bedroom house in Tunbridge Wells. Later we were able to employ a 'live-in' nanny and a housemaid, who came every morning and evening, and cooked dinner. I remember my wife complaining that she was quite exhausted on nanny's whole day off!

The abdication of Edward VIII brought dismay in early 1936, and at the end of the same year Professor T B Johnson called me to Guy's. He was to become the Director of what was later known as the Emergency Medical Service. This was set up in case of war; rumours of a conflict were already abroad, but I was sworn to secrecy. Pembury, he told me, was ear marked to be a large base hospital and I was to be put in charge of it, and oversee the construction of an additional hutted hospital in the grounds. He wanted the hospital to have about a thousand beds! I tried to explain to him that I intended leaving Pembury but he said I was not to go in any circumstances nor was I to think of joining the Services. I had to confess that I had tried for the RNVR, but had been rejected. He merely said 'good'.

1937 saw the said fiasco of Neville Chamberlain and the 'peace in our time' episode but plans for the EMS went on.

In 1938 I got my MD, and felt a little more settled and equipped; I had done all the obstetrics and gynaecology for some time and realised I was now committed to such a career.

Looking back, it is interesting to recall the set up in Tunbridge Wells. As in most provincial voluntary hospitals, a promising young doctor would apply to join a GP practice and, after some years, he could be appointed as an Assistant Physician or Surgeon (even though he may have done no surgery for years). There were some who had a FRCS, but all did general practice. With the exception of certain specialities like ENT, Eyes, Radiology or Pathology, all forms of surgery were done by them. There was no recognised gynaecologist for example, and all obstetrics was done by general practitioners.

The huts were finally completed in 1939 and it was only then realised that the greatly increased complement of staff and patients demanded an extension to the sewage disposal system as well as increased kitchen and laundry facilities. However, we were prepared for war.

Professor T B Johnson

I remember we were supplied with a large number of green stretchers, some quite dreadful bedside lockers and some hideous, galvanised iron food trolleys, which no self-respecting Ward Sister would have allowed in her wards, and which were totally unsuitable for our hilly terrain. The only use we could find for them was to support glass tanks containing gold fish. There is nothing more time consuming to patients confined to bed than gold fish in a bowl.

When War was declared on 4 September, I was distracted by an unexpected occurrence. One hundred and forty Guy's students arrived at my office, each bearing a chit signed by TBJ, saying that, in the event of hostilities they were to report to me, Surgeon Superintendent of Pembury Hospital. I hadn't the slightest warning of this and I didn't know what I was supposed to do with them. However, we appointed a Billeting Officer, and he managed to find accommodation for them in the village. They subsequently went to the transferred Medical School in Tunbridge Wells.

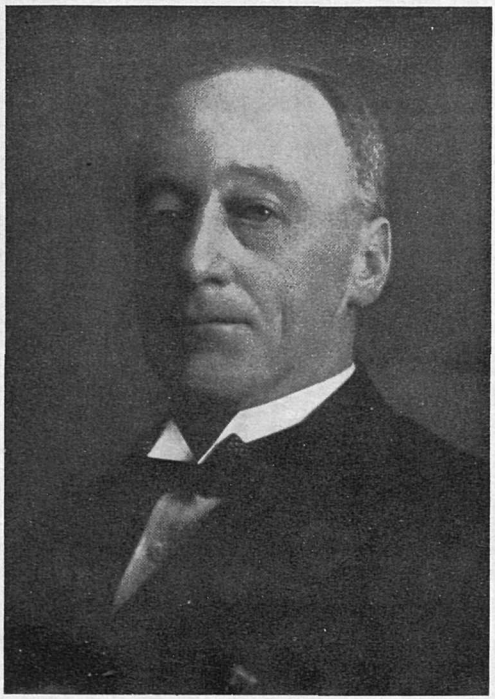
Gradually the senior Guy's staff and registrars arrived.

It was a pleasure to welcome so many old Guy's men including, as one of the first, Dr E P Poulton, the 'Oxygen Tent King'. I was on his firm as a student, and we waited his arrival on the landing of the stairs in Hunt's House. One of Poulton's earlier models was sited there—a boot shaped metal box with a window. The flat top had been marked out as a 'shuv h'apenny board' and we played endlessly! I wonder if it's still there? I remember one scintillating occasion when EP was doing a sigmoidospy on a female patient when he observed: 'I can find nothing wrong with the mucosa except that it is not very rugose, but there seems to be an obstruction higher up,' when a small, plaintive voice from the other end was heard to say, 'You're in the wrong hole, doctor.' Dr Poulton stayed only a short time—I believe he was ill at the time.

Harrold Chapple was another early arrival. He was always suave, charming and elegant—it was not surprising that he had a thriving private practice as a very fashionable gynaecologist. He had married one of Sir William Arbuthnot Lane's daughters who became a great friend of the family. I was delighted to see him and I shall always be grateful to him because he signed my 'books' for the MRCOG, enabling me to take the exam at a time when the Hospital was not recognised by the College. He was a splendid colleague and I worked with him a great deal.

E C Hughes (Joey) had a weekend cottage in Pembury. We knew him from before the War and had played tennis with him and his young family. He was a wonderful teacher and a fine colleague; he was universally popular and full of wisdom. Innumerable stories could be told of him, but one will always stick in my memory. We were sitting in the surgeons' room, having coffee whilst a list was completed in theatre, when we were asked to examine an elderly patient. He had a strange hard lump in the right iliac fossa. It was painless, firmly fixed and sarcoma of the bone had been suggested. There was no pyrexia and the man was not ill in the least—just complaining of the 'lump in me tummy, Doctor.' X-ray revealed nothing and other tests were negative. I hadn't the first idea what it was, but Joey palpated it while I was out of the theatre. He soon joined me.

'Drink up your coffee, Dudley—there'll be an almighty stink in a few minutes and theatre will be uninhabitable.' I asked why. 'Well. That's a chronic appendic



E C Hughes OBE, MCh

abscess in the theatre and when that's opened you'll see what I mean. I've seen these before in old people.'

Apparently when Joey had left the theatre there was a general murmur that the old man had gone mad to suggest such a silly thing, and they went on with the laparotomy. But, as Joey said, as soon as they tried to dissect the lump it burst and let out the most awful smelling pus anyone had ever experienced. The theatre had to be emptied and cleaned out before anything else could be done.

To my great delight Joey stayed on after the war as a Consultant Emeritus-Pembury and he was the last of the Guy's contingent to leave.

It was a time of comparative peace—certainly no signs of War—as we settled down but the even tenor was shattered by another unexpected arrival—fifty Guy's nurses. Matron had to deal with it because accommodation was a bit limited. Emily McManus, the Guy's Matron came down, breezed through the Hospital in her inimitable style, as if no problem ever existed, and said, and I

heard her say it to her 'girls' enduring the inconvenience of the times, 'My dears, there's a war on. Didn't you know?' Emily McManus was an inspiration. She breathed confidence, nothing to her was impossible, and she was a born organiser. The association of Guy's and Pembury nurses could not have been more amicable.

She became a great friend and my wife made a succinct observation after one of Emily's visits. She said, 'Emily McManus is the only woman who can make me feel at home in my own drawing room.' It was like both of them.

A A Osman was another arrival. He had been the renal disease expert and gave large doses of citrates, which alarmed his contemporaries but he did achieve remarkable results and was grateful to Pembury where he had, he said, the only unit given over entirely to renal disease since Bright's days.

Arthur Ormond called upon me to say that he was in Tunbridge Wells, and had been appointed to Pembury. He was the ophthalmic surgeon, with Sir Herbert Eason, at Guy's and we came to know him and Mrs Ormond well. I just remembered him from my days as a student, but he never looked upon me as eye surgeon material since the occasion when he invited me to incise a Meibomian cyst. I approached the patient with a 'loop'—a pair of impossible magnifying spectacles on my nose—and with my triangular bladed knife poised in my hand when I accidentally pushed the point of the knife into the tip of the patient's nose. It was a trivial prick really but, like all such assaults on the nose, it bled furiously. I was relieved of the weapon and never invited to perform again.

E D Y Grasby

to be continued.

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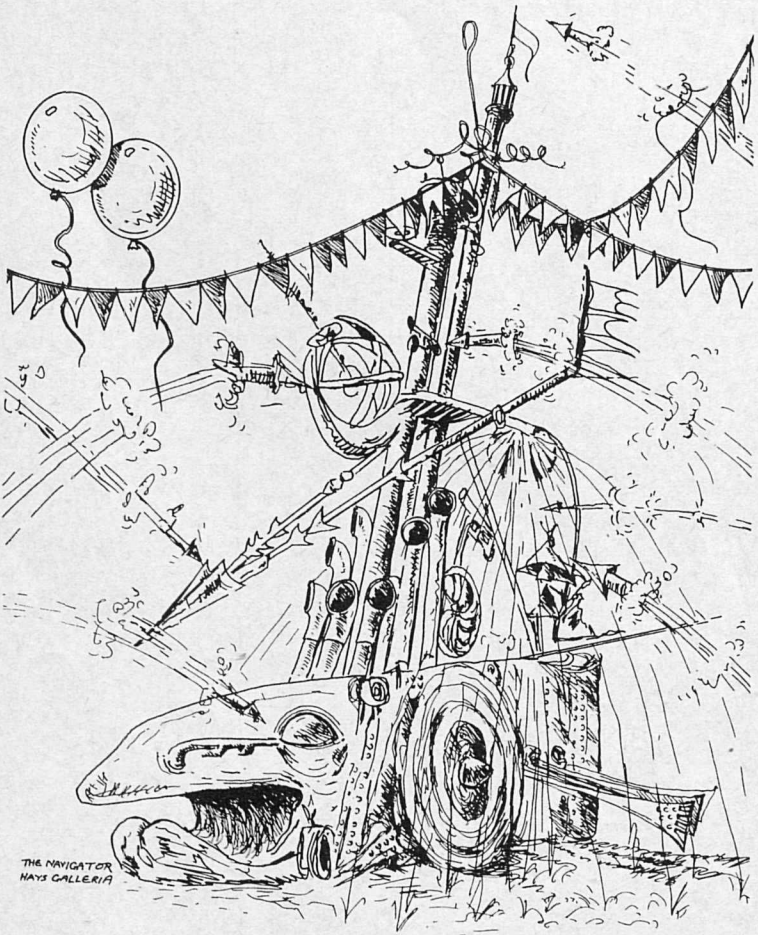

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Bungy Jumping

A very Australian pursuit

It was after Christmas in steamy Cairns in Northern Australia, when we managed to come to a group decision that we should attempt a 'bungy jump'. That great antipodean culture had provided the world with something it could be proud of, something more macho than drinking gassy lager, something more terrifying than death itself.

Edmund Hilary climbed Everest because 'it was there'. I decided to bungy jump because I could not come to terms with being called a 'yellow belly' for the rest of my life. So much for being an autonomous individual who controls his own destiny.

For those who do not know, bungy jumping entails hurling oneself from a great height (about 50 metres—higher than Wolfson house) with a length of elastic tied round one's ankles. Hooke's law says that the longer the piece of elastic is stretched the greater the force is, in the opposite direction of the motion stretching it. What this means is that when you reach the bottom, you are flung upwards towards the platform from which you jumped. However there was no guarantee, on handing the money for the privilege of entrusting one's life to a large elastic band, that the particular piece of elastic obeyed Hooke's law.

I overheard one British tourist who, quivering with fear, asked one of the 'Bungy crew' if the elastic was safe:

'Well, if it snapped you'll be back home before you know it!' His reply was gentle, reassuring, if a trifle ironic.

I had estimated on the way, that speeds approaching that of free fall are reached on a bungy jump, which is fast enough for one's dinner to be brought up, so breakfast consisted of toothpaste.

Several visits to the toilet, and a short minibus ride later, the 'bungy' gantry was reached. It was an exceedingly high wooden platform just visible through a clearing cut in a eucalyptus forest. Below was a small, muddy pool. We arrived to see a man leap off and an apocalyptical scream echoed around the clearing, which was quickly muffled by his head being submerged in the water.

He exhibited simple harmonic motion for about thirty seconds before coming to rest at the bottom.

'Oh, that does look fun,' I cried with an enforced grin, to those around me. The only thing that was keeping me going was the fact that my friends were more terrified than me and I was enjoying telling them stories of ropes snapping and horrible deaths.

It was a long walk to the top. On the way I was weighed, and my weight was written on my hand. This was crucial so they would gauge the correct length of rope to attach to you. My weight was 69 kg, a figure which our Australian friends found amusing. No doubt a few XXXXs would go down over a delightful anecdote about the pom who weighed the same as a well-known sex position.

My main worry was not being the butt of a rather poor sexual innuendo, but having my sweaty hand read upside down. I was getting the fear. I bet they think English people have big bones, I bet they give me too much elastic.

I had visions of being scraped off the bottom of the small pool, and having one member of the bungy crew referring to the other as 'Mate', saying, 'He didn't look like a 96 kilo man,' and then telling their mates over a XXXX how much lighter poms look than they really are.

I stood at the top with the rope tied tightly round my ankles. The man told me not to look down but to fix my gaze on the horizon. I immediately looked down to see a small green pool 160 feet beneath me, and hurled myself forth into oblivion. All I remember was not being able to scream or utter a word, and feeling my stomach creep up my neck.

It was rather like the scenario in a dream when the monster has chased you off the edge of the cliff, and you have no option but to dive off it, as an alternative to being eaten alive which is a disappointing fate at the best of times. At the same time, somehow, the monster has rendered you speechless, as monsters will.

I bounced up and down before dangling like a carcass in a butcher's shop. The fate with which I had met was by no means less gruesome than that of the carcass, though definitely more frightening.

That evening we experienced some of the finer touches of Australian bar culture. An activity entitled 'horizontal bungy jumping', which consisted of hurtling across a crowded bar, tied to a big rubber band, attempting to grab a can of XXXX. The rope tightens as the elusive can of beer is approached, and eventually drags the contestant back along the bar floor with nothing more than carpet burns. These grazes, though preferable to the elusive can of beer, remained the only physical stigmata of the bungy experience.

Neil Solomons

Taking Second MB

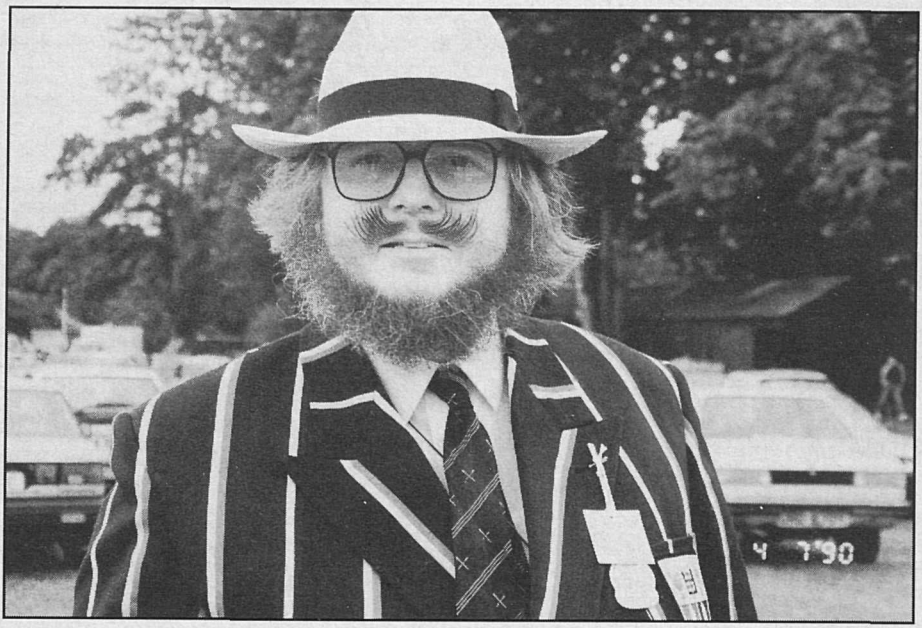
How things were in 1967

It's a wonderful thing it is—to be sure—to awaken on a Monday morning and know that I'll never have to take another exam in my life. I'd done the 'A' levels at 17 and now at 19 years 7 months there was this horror—the second MB. I seemed to have spent my entire life studying. Well—that's only partly true. Much of my study I'd been driven to by my late father, Frank Pitt-Payne, who held the view that women were *verbotten* and that to 'keep one's eye on the ball' was paramount.' Sadly, my hand-eye co-ordination was never that good, and so it was that whilst I should have been at HOP on a Saturday afternoon, I was—in fact—awaiting the arrival of a train from Cambridge which would steam in at about lunch time. Thereafter we would spend the afternoon in the back row of a darkened flea-pit in the Old Kent Road.

It was a time of steamed-up windows and evenings that got persistently lighter. Of such things there are happy recollections but the fact that I must have been studying anatomy, physiology, biochemistry, and pharmacology has completely gone from my memory. The weekend before the ordeal was spent at Deal and I did no revision at all on the basis that if I didn't know 'it' then I'd never know it at all. And on the Monday after—and for the next three days—there were six hours of exams per day. On the Thursday morning there was a shorter exam. The whole occasion seems like a distant dream now, as do the practicals which must have followed.

There was a thing called the 'flag-day' practical and if anything could have been ascribed the epithet 'fun' then this might have come near it. The dissecting room was laid out like some kind of charnel house with various bits and pieces arrayed with flags. As I remember it, each flag had a number on it and we had to write down what bit the thing was stuck into. Professor Jack Joseph wrote about this in 1976 in the special *Gazette* published when Guy's was 250 years old. This exam was negotiable but the one-to-one anatomy viva was a never-to-be-forgotten experience. I was tested by a short bad-tempered, bald-headed gentleman—dare I say, of questionable parentage—who gave me what can only euphemistically be referred to in retrospect as something of a bad time.

He was no Guy's man, I'm sure, and to be taller than him was a disadvantage. In the space of five minutes I'd been reduced in academic stature by what the Americans would have called his 'attitude' problem. Happily, I seemed to know all about the gall bladder which must have saved me from the wailing and gnashing of teeth that appeared to be the fate of those who failed. In all the years



Above: Dr Pitt-Payne at Henley

I took exams I never met anyone as rude as this and I can only assume that I must have got him at the wrong time of month.

There were physiology and biochemistry practicals; afternoons spent in the labs up there in the Medical School. Time spent comparing the properties of substance 'x' with substance 'z'. Time spent doing things with slides and soot machines that covered bits of paper with soot only for it to be scratched off by some machine that made a needle go up and down. I never really had a lot of time for the physiology lab. I fainted on my first day in the place when I watched Dr George Preston taking blood out of the ante-cubital vein of some mindless volunteer. Quite convinced that I was a bit of a 'sissy' I went and saw my first post-mortem after lunch the same day, but I digress.

I never quite understood why men and women who had gone to the trouble of getting a medical qualification should want to incarcerate themselves in matters of teaching us the rudiments of anatomy and physiology. In my case it was a case of 'pearls before swine' and yet somehow—mysteriously—I passed first time.

I remember the day quite clearly as something of an oasis in my own personal desert. It was Professor Jack Hunt who gave me the glad tidings. I can't

remember what he said; maybe something to the effect that I'd done alright in biochemistry—which was odd because I'd been bottom but one in the year the previous Summer—I got 23% which I was rather proud of—almost as good as my 0% in the mock physics 'A' level back in '65 at school. I draw a veil over the rest because it has gone from my memory; other than the fact that I had passed and it was a fine Spring day and that weekend I'd be off like a shot to Cambridge—and my eye would no longer be on the ball . . .

JHP-P

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Alan Yates

Alan was one of the most colourful sons of the Cardiac Surgical world. He was a great man in every way, full of vitality and humour and with an enormous capacity for work but above all he was a devoted family man.

He distinguished himself at school both academically and as an outstanding sportsman. He qualified in Sheffield, winning the University medal for 2nd MB, the University medal for final MB, a gold medal in pathology and five other major prizes including one in anaesthetics.

When he was courting Enid, he was highly amused and somewhat surprised to be summoned by the Senior Neurosurgeon of the hospital who wanted to know what his intentions were. Being Alan, he replied by asking the chief another question—'What exactly do you mean by that?'. The surgeon explained that Enid was the best theatre sister he had ever had and he just couldn't afford to lose her. Alan commiserated with him and said how sorry he was to be such an inconvenience. He married Enid the day after the university graduation ceremony and she was to prove a great tower of strength to him and without her he felt he would never have succeeded as he did.

Alan spent almost all his time at Guy's and did all his operating here because he believed in meticulous pre-operative assessment and devoted post-operative care which he used to regard as almost as important as the operation itself. He was the person who planned the Intensive Care Unit, set it up according to his meticulous requirements and trained the staff with great thoroughness. He personally directed it for 20 years, spending endless hours and giving his expertise to all the patients in his own unit and to other units as well.

He would start work early in the morning and often be at work late into the evening. There was hardly a Saturday morning when he didn't operate, often extending into the afternoon and in that way he continued until within a few months of his death. He shouldered his management tasks with the same gusto and enthusiasm that he displayed in all his other work. You always knew where you were with Alan. He always spoke his mind in a direct and friendly way. Talking to Alan was something one enjoyed. One rarely came away without having learned something worthwhile.

Although he had so much to be proud of, he never boasted of his success but would encourage his juniors and his colleagues with tales of his occasional failures and close calls in the surgical world. He regarded it as dishonest to pretend to be what he wasn't.

In the 1970's he went to the Middle East to help in establishing cardiac services. On one particularly hot day he plunged into the Mediterranean to cool off and swam across the harbour at a speed never seen before by his surgical colleagues. On questioning on his return, he admitted that he was interested in swimming and, yes, he had entered for a few competitions at school. We became suspicious at this and went on pressing him until, at last, the truth emerged. He had actually swum in the 1954 Olympics.

He was a skilful sailor and did this with his usual enthusiasm and thoroughness. He took an advanced course in navigation and worked hard for the examination with Edgar Sowton. He was always concerned about his friends and was worried that Edgar was going to fail the exam but, in the

event, he was very amused when Edgar came first and Alan second.

Whenever I saw Alan in the distance, I always made a bee-line for him because after every meeting with him I would always come away cheered up, inspired and grateful to have such a splendid friend here at Guy's. We salute the memory of an outstanding surgeon and a loyal and great son of Guy's.

IM

Bernard John Roberts

Bernard Roberts BDS(Hons), PhD, FDS, died aged 46 on the 3 April 1991. He had retired due to ill health from his position of Senior Lecturer and Honorary Consultant in the Prosthetics Department at Guy's four years earlier.

The son of a respected Midlands dental technician, Bernard qualified from the Royal in 1968. To help financially during his undergraduate training, he drove a coach at holiday periods and weekends, taking holiday makers the length and breadth of the country. In spite of these extra-curricular activities he still managed to collect six undergraduate prizes and the 1968 Gold Medal award. He did not, however, obtain distinction in Prosthetics, the speciality that was to become his chosen career. That was to come later.

After a very happy spell in a South London practice, Bernard divided his time between Unilever, where he worked as one of their staff dentists, and lecturing in the Prosthetics Department at Guy's. He took up a full time post at Guy's in 1973. Although his academic record was outstanding—he was responsible for 16 papers and with Mervyn Dyer he co-wrote *Prosthetic Notes* which is currently a best selling Prosthetics text—he will be remembered by most for different reasons. To his patients his academic record was irrelevant, because they knew the man. Today he is still fondly remembered, not only by his patients, but also by all whose lives he touched.

Bernard was above all else a teacher. Students hung on his every word, and they loved his slightly off-beat manner. As a new lecturer to the department in 1980 I had the privilege of being taken under his wing. We had many things in common, even to us both having three daughters, and we became great friends. As I look back I realize that my teaching methods, my examination technique, and even my patient management are modelled on his. A senior colleague, aware that I was to write these words, wanted it to be known how quick Bernard was to help in times of crisis and of his immense compassion.

The tragedy is that future generations of students will not be able to benefit from his teaching. His skills have been missed these past four years, a period of time which for Bernard was most unhappy. For the daughters he idolized, Eleanor, Imogen and 'his Frances', and for Gill, the knowledge of the universal high regard in which Bernard was held may help in some small way during these difficult times. There are very few like him.

Lyndon Cabot

John Maurice Lea

John Lea was born in 1904 at Leck in Lancashire, where his father, a Greek scholar, was Vicar. Maurice was educated at Marlborough.

His early desire to be a doctor was frustrated by bad sight in one eye and he trained as a wireless operator and joined the Merchant Navy. After several years however he applied to Guy's and was accepted as a student in 1929. He rowed in the Guy's VIII (1929 to 1931) and qualified MRCS, LRCP. In 1937 he entered a practice at Lifton, Devonshire where he was later joined by Royce Stevenson, also from Guy's. Later they both became Lay Readers in the Tavistock Deanery and in 1953 Maurice started training for work in Africa in the field of leprosy.

After the Redhill Leprosy Hospital, the school of Tropical Diseases, and the Oji Riyer Leprosy Centre, Nigeria, he was appointed Medical Superintendent of the Kumi Leprosy Centre, Uganda with a great deal of work both there and in numerous outpatient clinics.

He soon realised that with the shortage of priests he could, by ordination, broaden still further his service to his patients. The warden of Buwalasi Theological Training College supervised his studies and in October 1956 he was ordained priest by Bishop Stephen Tomasange. He could now take full Sunday services in the local language Ateso. Honorary Canonries of Soroti and of Northern Uganda followed and he was appointed Canon Emeritus in 1971.

By the age of 63 he found himself slowing in the operating theatre and was appointed Leprosy Control Officer for Northern Nigeria and moved to Gulu, returning with his wife Janet, who had accompanied him throughout, to England in 1971.

They settled in Newlyn, Penzance where Maurice continued to preach locally and for six months ran the Parish of St Peter's Newlyn.

The writer remembers him at Guy's as a tall impressive figure with a quiet persuasive manner and a long stride. One recognised a man of great quality in every respect. One is grateful to have been allowed to bring an account of the life of this Guy's colleague before the present generation.

He slipped quietly from this life during a Christmas visit by his family on December 31, 1990.

Maurice is survived by his wife Janet—*née* Jupp—whom he married in 1932. She was formerly a Guy's Lady Almoner. (Some of us will remember that their finely black and white chequered uniforms led to their being called 'sponge-bags'.)

Of their two sons, Patrick and his wife and family were present when he died. John was lost in a climbing accident in 1953.

Maurice Lea gave of himself all that he had all his life: in general practice in England and in Africa; medical treatment for lepers with valuable research projects; as well as care for their spiritual needs. In retirement he continued to contribute as long as he was able. Indeed a man one is grateful to have known.

PHS

John K Glaysher

That the Department of Prosthetic Dentistry is still endeavouring to come to terms with John Glaysher's death on 23 March 1991 is a measure of the role which he held in the Department. His job description was a highly individual one, embracing dental technology and research work. John's primary training as a dental technician gave him the formal qualifications as an FBIST but he was able to build on this from an abundance of practical common sense. These qualities made him a valuable assistant and collaborator in research projects and illustrator of published work. His informal duties as adviser, guide, host and friend for our overseas visitors grew from a warm personality. Whatever accommodation was arranged for such visitors, within a short period their practical base had been established in a corner of John's laboratory. This applied from the most distinguished visiting American Professor to the most recent of Japanese graduates. Many were entertained by Jean and John at their home and a plethora of favourable memories of Guy's now existing around the world owe much of their genesis to them.

Jean's support at home was crucial to John's rehabilitation after his subdural haemorrhage ten years ago. Although he continued to be irritated by his lapses of memory, we all learned to legislate for these and the latter part of John's career was as valuable and productive as any other phase. It was a recurrence of the haemorrhage that led to his death.

The family has asked that any memorial contributions should be made in favour of Cancer Research. These should be sent to Dr J D Walter, Department of Prosthetic Dentistry, Floor 20, Guy's Tower, Guy's Hospital, London SE1 9RT for forwarding.

JDW

John K H Culverhouse

Dr John Culverhouse FRCPC died on January 21, 1991 following a lengthy illness.

Born in London, England, Dr Culverhouse studied at Victoria College in Jersey. He held a position as accountant for the Union-Castle Mail Steamship Co Ltd in London. He served in the Second World War as a Major with the Royal Fusiliers Main HQ Eighth Army and was awarded the Territorial Efficiency Decoration.

Following the war, he studied medicine at Guy's Hospital. He emigrated to Canada in January, 1956. He was a member of the College of Physicians and Surgeons of Ontario and former Head of Department of Anaesthesia at Joseph Brant Memorial Hospital in Burlington, Ontario and his last position was Head of Department of Anaesthesia at Welland County General Hospital.

Dr Culverhouse is survived by: his wife, Hedy Scherer Scheiblauer Culverhouse; one son, Graham Culverhouse and one daughter Susannah Hirst, both in England; three step-daughters, two grand-children, and one brother, Lt Col Graham Culverhouse. He was predeceased by his first wife, Mary in England in 1942; his parents, Herbert and Lillian Culverhouse and one brother, Gordon.

Doogie Howser MD

I am American bred
I have seen much to hate here—much to forgive,
But in a world where England is finished and dead, I do not wish to live.

Thus Alice Duer Miller wrote in 1940, in her poem *The White Cliffs*. Tough times; straight talking; but essentially a charitable verdict. Can we say the same of *Doogie Howser MD*, possibly 1991's most worthlessly extravagant TV import? I fear not: the fantasy simply does not survive transatlantic travel: but this derives essentially from the concept, not the content.

Writing for an English medical journal forty-one years ago from America, where I was working as a Resident (Anglicé, Registrar) at the Massachusetts General Hospital and Harvard Medical School, I made a small stab at the vitually impossible: to convey something of the emotional complexity of that combination of exhilarating enthusiasm and constrained criticism inseparable from the experience. Americans 'Get Things Done', believe in superlatives, and have a weakness for overpromotion of what we now call job descriptions. Ex-servicemen and women are called veterans, no matter how brief or inglorious their service. Intercity trains, even as parochial as Boston (Mass) to Portland (Maine) have names; and, perhaps most telling, every medical student becomes MD on qualification (graduation). Hence Doogie's doctorate is for real; not the courtesy title extended to British colleagues whether their status be baccalaureate or licentiate.

No other American doctorate is so readily awarded. PhDs can be heartbreaking, Doctor of Laws, the highest academic degree obtainable. But even so Dr Doogie could not have been much more than eight years old when embarking on his chosen profession.

A recent *BMJ* middle article[1] gives the minimum period of time between graduation and the opportunity to take the MD. The average for the nineteen universities surveyed is 3.4 years. This establishes the MD as a prestigious higher degree, which combined with Membership of the appropriate Royal College, can open the door to Consultant Status. A very distinguished (now deceased) colleague of mine returned from student wartime evacuation to the USA with an MD from Duke University, and was thereby spared the hassle of getting one here. Contrast the plight of the authoress of Personal View 'Is it worth it?' (*BMJ* March 9, 1991) '. . . Experience and clinical ability are irrelevant—it's an MD that counts'.[2]

Is the concept of a sixteen year old doctor comprehensible to a British TV audience? Is pretentious emotional immaturity intrinsically lovable? What about the true story of the British twelve year old girl whose genius for mathematics gained her an immediate place at Oxford? That *was* one for the record. Doogie Howser MD was not only unbelievable, gauchely precocious, and innocently insufferable—for at least one Americanophile viewer, he was terminably unwatchable.

DS-C

References

(1) University Requirement for Higher Medical Degrees. Council for National Academic Awards. Handbook. London 1989. *BMJ*, 16 Feb, 1991, No 6773, Vol **302**, p 397.
(2) Sheena Pinion. Personal View. *BMJ*, 9 March 1991, No 6776, Vol **302**, p 599.

Lecture Notes on Epidemiology and Public Health Medicine. Richard Farmer and David Miller. Blackwell Scientific Publications, 1991. £11.95.

This is the third edition of what was previously *Lecture Notes on Epidemiology and Community Medicine*. The publishers have produced an attractive new format and the authors have responded by 'coming out' with their forenames instead of initials. The contents of the book are much as before, though there has been some sensible re-arrangement of material and a number of new examples have been added or have replaced more venerable ones. Immunisation schedules have been updated to current recommendations, but the section on the National Health Service was written before the 1990 Act was passed and even before FPCs were translated into FHSAs. That apart, the book can be thoroughly recommended as a suitable text book for the London University MB examinations.

John Jarrett

Principles of Physiology, ed Berne, R M & Levy, M N Wolfe Publications Ltd, (Mosby), £19.95

As we have come to expect from American textbooks, *Principles of Physiology* is beautifully laid out and illustrated, with a good index. The authors state that they set out to cover the essential principles and underlying physiological mechanisms thoroughly keeping non-vital detail to a minimum. To a large extent they have succeeded in their aim and the book could be recommended to someone seeking a clear basic account of physiology. However, many of the topics that the authors consider 'non-vital' are an essential part of the BMS Physiology course at UMDS and hence this book could not be recommended as a comprehensive text for medical students. For example, the respiratory physiology section does not cover dead space, dynamic compression of airways, FEV_1, peak expiratory flow, diffusing capacity, helium dilution or body plethysmography and its coverage of chemoreceptors and acid-base physiology is inadequate.

Medical students would find the rather larger text *Physiology* by the same editors (Published by Mosby at £21.95) more suitable for the UMDS course. The illustrations are less colourful, although equally clear, but the content more comprehensive.

Jane Ward

Self-Assessment for MRCP (Part I). Corke. Third Edition. Blackwell Scientific Publications.

The use that is made of the multiple choice questions in this book distinguishes it from many other books or MCQs for Part 1 MRCP. As is rightly pointed out in the preface, multiple choice questions should be an aid to identifying areas of weakness during study rather than being the main source of factual knowledge. The book is set out in a way that corresponds with this approach, with extensive notes referring to each question, useful either for checking answers or for revision.

There are a few errors of spelling; Campylobacter has now been renamed; the notes are not always set out logically with respect to the individual parts of each question, and there is a conspicuous lack of reference to the *Oxford Textbook of Medicine*. Apart from these minor criticisms this is a useful book, which encourages a realistic method of study for the examination.

I D Starke

Lecture Notes in Cardiology. Third edition. Aubrey Leatham, Catherine Bull and Mark V Braimbridge. 352 pages. Blackwell Scientific Publications. £12.95.

This new edition is a very attractive book, with a large number of clear line drawings provided to explain important points in the text. Despite its title, it is much more appropriate for a postgraduate reader than for an undergraduate, since it contains detailed descriptions of congenital heart disease and of the different surgical options for the treatment of ischaemic and valvular heart disease. Although the requirement for relative brevity has made the text somewhat over-prescriptive in places, an important weakness of the book is that just where the advice needs to be precise and didactic—in the section covering the management of cardiac emergencies—it is vague and ill thought-out. In describing the drugs given in the treatment of cardiac arrest, the first drug mentioned is sodium bicarbonate, followed in order by adrenaline and then calcium chloride. Lignocaine 1% is mentioned but its dose is not, and the indications are not given for any of these drugs except sodium bicarbonate! It is unfortunate that this section is so poor, since many undergraduates who are revising for their finals will consider the topic of CPR to be the most important of all that they have to learn, and to find such an inadequate explanation in a text supposedly devoted to cardiology tends to make one worry about the reliability of the rest of the book. This is a pity, because for the most part it is clear and helpful.

Essentials of Clinical Examination—a question and answer guide for students. Donald G McLarty. 160 pages. £4.95. Balliere Tindall.

This is an excellent little book for any medical student trying to sharpen up his or her approach to clinical examination, whether this is at the time of first exposure to patients on the ward, or when revising for the clinical part of finals.

The book is written in question-and-answer format and is organized system by system. There is very little explanation of the answers, so that the book would not be adequate as an introduction to clinical examination, the questions would make an excellent way of testing one's understanding and recall after reading, say, a chapter of Macleod. For finals students, they comprise a handy, white-coat-pocket-sized 'portable *viva*', at a price which will hardly strain the resources of even the most overdrawn. It is thoroughly recommended.

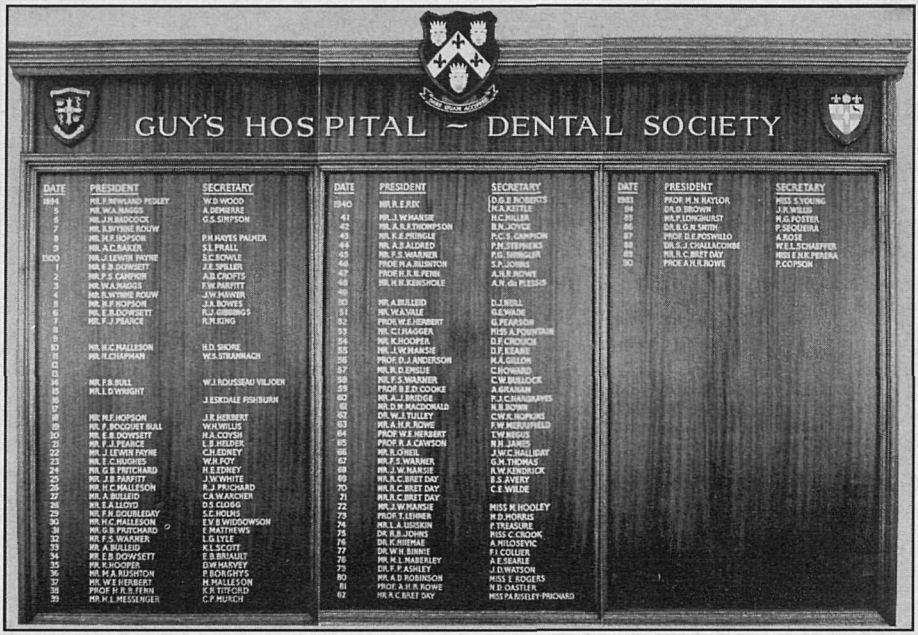
Roll of Honours Board

Saint David's Day marked a most significant occasion in the history of the Guy's Hospital Dental Society. Gathered for the ceremony were three former Deans of the Dental School and at least twenty past Presidents of the Dental Society that was founded by F Newland Pedley in 1894.

The Dean, Professor Rowe, introduced the proceedings and welcomed those present, many of whom had travelled a great distance for the event. He then called upon Mr James Mansie, who has been President four times, the first being in 1941, to unveil the Board. I am reliably informed by a number of his students present that Mr Mansie looked younger now than when he had taught them. He made a very witty speech in which he recalled memories of Kenneth Hooper 'The last of the gentleman dental surgeons'. Mr Hooper, as many may remember, was a tall, elegant man who took great pride in his appearance and provided an example for others to follow.

Mr Mansie then unveiled the Roll of Honours Board; situated outside the entrance of the F S Warner library, it is indeed magnificent. The Board is the result of many years work by numerous people. Mr John Cardwell nurtured and maintained momentum for the idea through numerous changes in Society membership, and it is to him, therefore, that the thanks are primar-

The Past Presidents of the Society gathered for the ceremony. Back row, left to right: Prof R B Johns, Mr R C Bret Day, Mr M L Maberley, Prof F P Ashley, Prof A H R Rowe, Mr R O'Neil, Mr A D Robinson, Mr P Longhurst, Prof T Lehner, Prof D E Poswillo, Prof M N Naylor, Mr L A Usiskin, Dr D Brown.
Front row, left to right: Prof R D Emslie, Mr A R F Thompson, Mr J W Mansie, Prof W J Tulley, Mr W A Vale, Prof D J Anderson.



The Roll of Honours Board: if you can help fill in the spaces please let us know?

ily due. John and David Radford were also heavily involved in seeing the project to its conclusion. John was concerned with the 'nuts and bolts' of the project; he obtained the necessary materials and monitored the construction with a paternal eye. David had the unenviable task of making sure the names and dates on the board were correct. Much of this information was found by searching through past Minutes of the Society, usually meticulously hand written.

Some of the names on the board are particularly interesting. F Newland Pedley was the first President; then 4 years later we see the name of Montague Hopson, who was the first dental student at Guy's. Our present Dean has made a unique contribution, being the only student secretary (1949) to become President of the Society (originally in 1963 as Mr A H R Rowe and later as Professor Rowe in 1981 and of course 1990). Searching through old records David in fact discovered a hand-written minute by Professor Rowe when he was student secretary reminding himself to thank particular people at the next meeting.

Looking at the board it is interesting to note the transition in titles of the past Presidents. In former days the Presidents were all 'consultant dental surgeons' being addressed as 'Mr'. Now of course many of the Presidents have academic posts and similar qualifications. The first change of

title we find is that of Professor Fenn (President in 1938 and again in 1947) who was, of course, Professor of Prosthetic Dentistry and in fact this appointment in 1935 was the first dental chair at Guy's.

The Dean and Mr Bret Day have both been President on three occasions, and it wasn't until 1953 that Miss A Pontain ended the male domination of the society and became the first lady secretary.

After the ceremony, photographs of our visitors were taken in the Warner Library and we had a most pleasant reception in the Committee Room.

In these changing times it is essential that we guard these traditions and remember the achievements of our past teachers at Guy's; the example they set and pride they instilled in their students; qualities that must be maintained for our present and future generations.

Lyndon Cabot and **David Radford**

Nursing Standards

When nurses carry out tasks with patients there must be an effective standard against which to measure the effectiveness of the action. The problem of measuring these standards, though, is not as simple as at first it may seem. Auditing nursing procedures is not quite like profit and loss accounts that affect a supermarket business.

But such is the political climate today that all public services have to be rigorously tested in order that they aspire to the standards supposedly demanded in their competitor, the private sphere. One standard that all nurses might expect is that they were paid better to keep their sights alongside those found outside the public sector of service.

Surely the increased 'turnover' of patients achieved in many hospitals should be a good guide for recompense in any productivity measurement as in the private sector?

The 'Citizens' Charter', proposed by the Adam Smith Institute, can be an admirable base for criticism that is made of nurses and others who work in the public sector.

However, I am amazed at some criticisms made of our services when compared with the private sector. It is almost as if once a service is outside the public field then it is at the acme of of perfection. Have none of these critics ever been dissatisfied when they shop or buy a car? Buying or having a car serviced is an entirely 'private' affair, but on my own knowledge, and the reports of consumers' groups, car buying and service is fraught with an endless stream of complaints, many of which are not settled to the customers' satisfaction.

I would go so far as to say that the standards set in nursing, although maybe elementary compared to those associated with car purchase and use, are entirely favourable to nurses. But do patients complain about nurses in a manner similar to that they would apply to someone selling

them a secondhand car? I would doubt it: firstly, the nurse as 'angel' image inhibits some complaints that may be justified, secondly, because some, maybe many, procedures which nurses carry out on patients are inherently unpleasant and painful, patients may be unaware of whether they should complain or not. In some instances only other peer professionals can judge whether standards are being met, or not. Patients may not wish to risk the outcome of complaining!

Once standards have been established then we must all see that they are met and various models can be set up to discover if these objectives are reached. This must see the patient at the centre. We know the idea that 'the customer is always right' is not observed to the letter in all private business: this must not be so in health care. Explanations must always be at hand for a patient concerning whatever procedure a nurse is carrying out, and the attempt made that this is fully understood.

Denis Cobell

PHYSIOTHERAPY NOTES

Good Bye St Olave's

The Rotherhithe Workhouse was first mentioned in the vestry records in 1722. By 1864, and various infirmary wards later, the institution was known as the Bermondsey Infirmary. It was re-named the St Olave's Infirmary in 1891 in memory of Olaf of Norway who helped Ethelred (the Unready) II in his fight against the Danes around 1008–1013. Much around this part of the river carries his name and the Norwegian Church stands at the south entrance to the Rotherhithe Tunnel.

Between 1908 and 1912 the Infirmary was renovated and subsequently accommodated 600 patients. It came under the local authority administration (LCC) and was again, in 1931, renamed. This time it became the St Olave's Hospital.

In 1932 it became affiliated to Guy's when it was selected, with St Alfege's in Greenwich, Lewisham and Lee Hospitals, to help with undergraduate teaching. Teaching rounds were given by Guy's staff on one day in the week.

Like Guy's, St Olave's was badly damaged in the London air raids and lost the Maternity Block. The X-Ray Department and the Pathology Laboratory were badly damaged. Chaucer Ward (Day Hospital) which still stands on the right immediately within the entrance gate, was put up on the Maternity Block site. At construction it had a life expectancy of 6 years. Next to Chaucer Ward stands the Physiotherapy Department which is also a prefabricated building.

Immediately prior to its temporary closure in December 1979 there were 232 patients in the main hospital which housed general medicine, some surgery, mental illness (adult and elderly) and a preconvalescent or Homeward Bound Ward

Above: St Olaves Hospital, Lower Road

which was completed in 1972. The Nurses Home had 140 rooms and was being upgraded right up to the point of closure. Other facilities on site were two doctor's residences at the main gate, a school of nursing and an outpatient building. This was originally intended to be a drug addiction centre and was completed in 1968 but never used as such. It was used as an outpatient department up to 1983. Samuel Pepys Ward was upgraded in 1979 to be used as a Day Hospital for elderly people with mental illness. It was closed before it could be opened.

An extra-ordinary piece of work was carried out in 1982—3 years after the temporary closure of the main hospital—under the energy conservation scheme. The obsolete boiler house was replaced by a new boiler house which served all the buildings on site, closed and open, except for the doctors' residences. As reported last month, the physiotherapy service actively survived until 10 May 1991 when it closed with a lunch-time party. The Department was then finally closed by 17 May 1991 and all equipment moved to alternative sites.

60% of referrals in 1982 were direct GP referrals. This had grown to 96% of referrals in 1990, showing that the close-knit community network was still active and growing in Rotherhithe. Although the Docks had closed, this community hospital, formally endearingly known as the Docker's Hospital, was still very much alive in the form of the Physiotherapy Department, which had won the battle to remain on site with the psychiatric services. I understand that Chaucer Ward is to be rebuilt and will be joined by a Domus for elderly mentally ill residents and another nursing home. St Olave's House remains.

Congratulations

Firstly I must begin with congratulations to those students who were successful in the recent union elections. I hope that all students will give the new campus committee their support and will get involved in all activities.

I personally look forward to attending freshers week and hearing about the Snowflake ball. May they both be very successful, well attended and profitable.

Charities week has been and gone. Thankfully without too much disruption and mayhem. The Hit Squad fulfilled their duties admirably and the innovation of *The Cage* was very well received. Thanks must go to Don Ellis and his committee for doing a great job. I also must thank the Spit men and women for putting up with daily mess without grumbling.

Finals are upon us. Fourth and fifth years are by now in the midst of their exams. Good luck to everyone taking part—I hope that all from Guy's are successful.

With the coming of summer some of our thoughts turn to post-exam Balls. A well attended Rugby Club Ball has already taken place in the original setting of London Zoo. We have the Final Year Ball, Physio Ball, St Thomas' Ball and Nurses Ball to look forward to. Get dressed up, get out there and enjoy yourself.

On a sadder note I see Mr Les 'The Lend' Evans has retired as manager of the Guy's Nat West Branch. We all wish him well and hope that his replacement will be as understanding and accommodating.

Finally thanks to all outgoing committee members for all the hard work they have put in over the past few years. Jim Lewis, Paul Frisby, Andy Klein and Gordon Kooiman all deserve special thanks. Be assured boys that your reward will come in heaven—it certainly is not here on earth (*Shurely shome mishtake—Ed*).

Richard Russell
Guy's Campus President

Rugby Club

Guy's 1st XV 19, Purley 26

Guy's completed their 1990/91 league programme with yet another 'if only' defeat. This week's was: if only all team members knew where the Purley ground was so we could have played the first ten minutes with more than 12 players. Neither side was playing for promotion or avoiding relegation, so in that sense it didn't matter. But defeat left Guy's in ninth position in the eleven team league, the lowest ever and only one place away from relegation.

Before the final three had warmed up, Purley had a thirteen point lead, which they had found difficult to achieve against the spirited Guy's dozen. Twenty five minutes into the game Guy's began to settle and a try by full-back Andy Hall gave some hope. The whole back division began to excel and made good use of any possession that the forwards managed to win from the hard struggle up-front. After another Purley try, Guy's fought back with tries by Neil Davies and Graham 'Hand-off' Bevan. Purley were awarded a dubious try to which Geraint Thomason took vocal and personal objection. However for a lengthy period in the second half Guy's trailed by only four points and the team tried not to dwell on Alan Jones' dropping of the ball when over the try line. As the game reached its climax Jamie Barwell strayed a little too far and with the last kick of the game Purley secured the game and fourth place in the league, and Guy's were left to mutter 'if only'.

Geraint Thomason

Bordeaux Tour 1991

The tour started badly; 6 am on a Sunday is always bad for me. After last year's experience the airline staff seemed quite happy to let us on the plane, they seemed almost cordial. You can tell the difference when the tour organiser is equipped with both money and academic qualifications.

On arrival we thanked, from our heart, the bearer of that great intellect (no, not Graham Bevan), as a possible Sunday fixture had been declined leaving the afternoon clear for Matteus Rosé to provide the half-time (and second half) entertainment for the crowd at a Toulouse match. He rose to the occasion. Touring can be such an onerous chore—one feels obliged to live up to people's expectations.

The Monday was the day of the first game, so everyone went to find out how much they could drink. Jamie Combes and Simon 'I hate French people, I know I lived with them for a year' Bunting decided to teach the locals a lesson and so visited a nearby school and did just that. Dentists, yet versatile.

The spectators at the game that evening enjoyed a fast-flowing spectacle and that was just the pitch. The Toulouse Medics set out to confound the school of thought that believes half a bottle of Pernod improves your athletic performance (although it does depend where you put it). Bill Murphy, rather unfairly playing in position, scored a wonderful try that no-one can remember and Steve Lewis parascended a penalty, but the Medics scored more points (19–7) and were awarded the game by the referee. Luckily our hosts provided ample opportunity for us to eat, drink and be not too down-hearted.

The following day a galley sailed us to the medieval city of Carcassone. Here a boarding party comprising eighteen pirates

and Mike Seare, as an overweight Noel Coward, swept through the town (which was very pretty, but don't tell anyone that I noticed). Escaliber was liberated and the games commenced.

Next stop Bordeaux. Our quaint suburban hotel reminded Jim Boothroyd of the shoe box he had grown up in, although these had been moved from the middle of the road and put in a petrol station. Chateau with an 's'. Off then for an evening game against our old *amis* Bordeaux Dentists. Before we played them, however, Bordeaux University 3rd XV insisted on a game as we were to use their club-house, ground and, no-doubt, their ball. A thundering display by the Guy's forwards and tries from Captain Worth, Guy Selman and Pat Gush made it a convincing 14–0 and the University left the field glad it had only been a 20 minute game. The next lambs were the Dentists who were unable to extract anything from the game and Murphy, Gush and Roy 'le garcon' Cunnington (twice) contributed to the 20–4 victory. Many carafe's were consumed after, mostly 'in one' as that it would seem is how the French prefer to enjoy their wine. Much hearty singing followed, with Welshmen and Yorkshiremen leading the way.

The French do have style. A chateau crawl. The Dentists kindly took us along on what seemed to be a private club outing and laid on a wonderful spread over which their Prof David spoke unintelligibly for hours while leaning on Mike Seare—probably more comfortable than any bean bag.

A buzz of excitement enveloped the tour party on the following day for this was the day when the cavalry would arrive, possibly including the legendary Charlie 'Machiavelli' Beardmore. They arrived, he didn't, Barwell's fault, everyone happy. Our next match was versus Agen Le Passage, as the French nurse told her constipated patient. Guy's had a difficult first half and despite an opportunist (and quite brilliant) try by Geraint Thomason, trailed by 9–12 at the half. Jeremy Worth is very much from the Will Carling school of total captaincy and will go to any lengths to motivate his team. Despite being a spectator, our Jeremy contrived to get head-butted by an Agen player at half-time, hoping that the sight of a bloody, bemused captain would galvanize the team. It worked and Guy's played with creditable commitment and controlled aggression to run away with the game 34–18 with 14 points from the boot of Steve Lewis and second half tries from Ross Llewellyn (2), Bill Murphy and, an incredible 60 yard solo try by Richard Breeze, on the course of which he side-stepped every Agen player at least once. The hospitality after the game was excellent and everyone had a good evening, helped by the fact that Bunting was unconscious and therefore, quiet.

The coach journey the next day was very long, which was surprising as we were only travelling a few miles (Seare's fault). Speaking of 'L'escargot gross', as I remember little about this day, I turn to Seare's diary to give you a flavour of what the key events were 'French meal v good. Craig paid £50 then gushed up. Matt dead'. A horrifying insight into the workings of the tour organisers mind.

On the Sunday morning we were taken to a stud farm to check out the stallions—I'm sure I saw Paul Scanlan there. It was very interesting, but I think we would have been more interested in our pillows at that moment. Oh well, far worse to come.

We arrived at the Pompadour ground for our final game to find that people were being charged 30FF to spectate. We were a little early (not like us), but the opposition

were already warming up. The word 'mismatch' doesn't do justice to the situation and by half time we trailed by 34–0. A second half rally and tries by Graham Bevan and Steve Lewis meant we only lost the second half 20–10 and we had some consolation that we had kept them under the psychological 55 point mark (we were desperate to think of something!)

The final evening featured Judge Boothroyd's court at which the prosecution counsel (me!) was so successful that not only were all seven defendants found guilty, but also the defence counsel. Mike Seare went down for a whole catalogue of crime (including being the fattest on tour, which he tried to deny!) and duly drank a bottle of wine through the Judge's jockstrap. The evening concluded with Chantelle and Shirley the sheep shivering in Seare's chalet shower (or something like that).

A good tour, with a lot of rugby and entertainment, though I still hate getting up at 6 am.

Geraint Thomason, PR Officer

Tour Party J Worth (capt), M Seare, G Thomason, J Boothroyd, C Cowan, B Murphy, J Murphy, R Llewellyn, W Llewellyn, P Cunnington, J Coombes, J Costello, S Lewis, G Selman, G Bevan, P Gush, G Ryan, M Rose, S Bunting, R Breeze, A Skyrme and P Rowe (who?).

Going Dutch, Third XV Tour, Amsterdam, April 12–15

The journey from the Guys bar to Gatwick was largely uneventful. There were a few scournful glances at a party of excitable, overgrown schoolboys, some dressed extravagantly. On the aeroplane too, there was relative harmony. The flight captain set the tone for the whole tour. His hyperbolically calm, upper caste voice suggested that he might be flying the craft with his feet, a beer in one hand.

Between the central station and the Ancker Hotel was a short but thirsty walk. A charming landlady met the party at the airport and guided it to her bar. The establishment was really a bunkhouse, well known to Eurorail travellers. Its facilities were primitive but a 24 hour bar and all night food were adequate compensation. There were tentative skirmishes with Amsterdam's nightlife and cuisine. No doubt there was discreet sinning. Some were ejected from a homosexualists bar; presumably they lacked the credentials. A new definition of stoned was coined when an apparently eperienced member bought a stone, having been convinced by the salesman that it was an exotic substance. At least he haggled. At the hotel, a door in its frame fell mysteriously with a crash; the oldies were dragged from their beds to play drinking games at which they refused to excel.

The bright morning sun was no help. Pale, unshaven, some wearing sunglasses, the team bravely faced the day assisted by multiple pots of coffee. A new door was paid for and in warm spring weather Amsterdam was explored by day. To walk alongside canals, sit at open-air cafes, to sip an aperitif and admire the church steeples, to watch the girls and hear the cacophany of clock chimes and barrel organs was enchanting. Alas, it was too much for some. The coach driver waited

patiently for the team to assemble for its first game. Ninety minutes late, overwhelmed by some canalside experience, a disorientated rump of players was reminded where to find its boots and dragged aboard.

The team was not at its best against Wageningen. There were moments of unintentional brilliance but mostly it was farce. Amongst the backs there was confusion as the outside-half tried juggling, heading and even smoking the ball before he was led gently to the long grass where he completed his reverie. Another crawled to the touchline, overcome by copious regurgitation. Beardmore was laid—by a punch he would ordinarily have seen. Thus sobered he scored as did Combes and Selman. In the second half, the game slipped from the referee's control and after 20 minutes he blew the whistle just as Guy's began to exert a belated authority. The score was a defeat for the hospital, 16–30. In the fine evening warmth, the Guys players entertained their hosts, one of them cooling his overheated imagination in a canal.

Back at the Ancker the lovely landlady was waiting at the bar. Thus fortified, groups wandered into the night.

Church bells and further bright sun roused the lightest sleepers. One player, moved by some nocturnal spectre in an ill-defined establishment sought morning confessional. Most remained in bed until a jug of Guinness was obtained for lunch.

The second game was against the Pink Panthers, a stylish club at Driebergen. Their shirts and goal-posts were luminescent pink. Anaker, the local witch, acted as confidant and doctor to the team. She sprinkled salt on the pitch as an act of goodwill, or so it was assumed. It failed to help the Panthers who encountered a Guy's side that was anxious to forget the previous day's game by playing some of the best rugby of their season. Helier opened the scoring with a brilliant solo effort, running, kicking, dribbling then catching the ball over the line. Guppy made amends by taking the ball repeatedly into the opposition then releasing it to an advancing player. The forwards dominated the tight play and Beardmore took revenge on a hapless Dutchman who knew nothing of the previous day's mishap and happened to have the most delightful girlfriend whom B befriended moments before the game. In a remarkable transformation, the forwards discovered the technique of the rolling maul, something which had hitherto eluded them. The backs played fast enterprising football which the opposition came close to emulating. White left the field with a leg injury but returned in haste when Anaker muttered an incantation over his writhing form. Tries were scored by Linney, Gibson, Beardmore, Selman and Morris and Combes managed two, Guy's winning 36–18.

In the clubhouse there was much fraternisation. The Guy's men sang well, mostly in tune. An early kick-off meant a long period of celebration which continued eventfully on returning to Amsterdam. Several bars were visited, one player had two close encounters, escaping from one by the skin of her teeth and the other after the intervention of the President. The hectic evening drew to a weary close after sundry cultural exchanges. Nobody missed the flight the next morning. Congratulations to James Combes and Guy Selman for their organising such a memorable tour.

Tour Party: J Combes, G Selman (Capt), J Hawker, S Helier, R Dales, S Bunting, H Morris, A Slade, C Beardmore, N White, M Sear, C Howell, T Gibson, D Guppy, A Linney, K Underwood, S Russell.

Hockey Club

Guy's Club Tour

Welcome back! At the moment we are all recovering from the tour where we took part in the 'Velsen Easter Hockey Tournament' at Strawberries Hockey Club in Holland. Our report is as follows:

We got off to a much better start than last year, as when we left the 'Shoes' both minibuses were intact. We got to Holland with very few hiccoughs (shame about Johnny and Ken). Once there, we played three days of hockey combined with numerous 'Amstel' breaks. Most of the teams there were of a better standard than us, for instance Devon County U21, The Undesirables (National League Division 1) and a few of the continental squads. However, we were the team with the most co-ordinated kit.

The nightlife was very enjoyable and we came across some very amenable pub and restaurant owners. The food and beer were excellent and Richard Russell declared that the strawberry mousse was quite exceptional.

The freshers entertained once again, Guy and Rob showed us how well they could juggle and both of them wore quite unusual hats whilst doing so, Guy's resembling an Elk and Rob's an ornate birthday cake. Sampi's fan club met him as soon as we arrived, whereas Pete did not really have one.

On leaving, there were a few sad farewells which delayed us somewhat but we made it to Belgium in good time. Unfortunately, near France one of the minibuses ran out of petrol and had to be towed across the Franco-Belgian border. We filled up in France and for the second time during our trip a petrol cap was mislaid (we're not sure who could have done it). The ferry crossing went well and a meeting was held onboard, jointly chaired by Captain Kooiman and Lieutenant Thompson. Both officers doled out penalties for heinous crimes committed on tour.

We reached London in time for breakfast and settled down for some 'Spit' coffee, which concluded a tour enjoyed by all.

Finally, we thank our president, Mr John Spencer for his continued support and also Eric and all the staff at HOP for what has been an enjoyable season of hockey.

Gordon Kooiman and Abhimanu Lall

Golden Anniversary

LAWRIE-GRANT. On April 12 1941 at St Giles' Church Oxford, REX LAWRIE to JEAN GRANT.

Deaths

TRICK, Edith Mary (née GIBBS) on April 13, 1991 in Suffolk, Widow of Scott-Russell Trick (Guy's 1921–1927) and was 'Sister Evelyn' and trained at Guy's.

POST, Stanley, LDS, RCS, Eng. Died on Dec 10, 1990 peacefully in his house at Brentwood, Essex. He has been a great friend to many and will be greatly missed by his wife and family.

On May 5, in Guy's Nuffield House, Pamela Ann JOSEPH, aged 56, dearly loved wife of Dr Michael Joseph and very much loved mother of Philip and Deborah.

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If not wearing A.O.F.B. Links when challenged.

This book and contents are written and copyrighted by Bert Temple.

Submitted by Mr E D Y Grasby, above is the Frothblowers Membership card (see April *Gazette*)

Guy's Gazette

Reader questionnaire

The Editor and staff of the *Guy's Gazette* are keen to improve the appeal of the *Gazette* to our readers. To this end we are conducting a survey of all our readers. It would be very helpful if you could complete this form and return it to Guy's Gazette, Boland House, London SE1 9RT, as soon as possible. Please circle the appropriate answers.

Are you:

A student: medical dental nursing physiotherapy

Staff: please state department/position

Ex-Guy's: medical dental nursing physiotherapy other

How often do you read the *Guy's Gazette?*

Every month Sometimes Rarely Never

Which of the following do you read? Please use the following code:

3 = always 2 = sometimes 1 = rarely 0 = never

Passim	Correspondence	News . . . .
Interviews	Article/features	Book reviews . . . .
Physio notes	Nursing Notes	Obituaries . . . .
Sport	Hospital info	

Which of the following would be of interest?

Calendar of events at Guy's/UMDS
More interviews with people at Guy's
More news of hospital events/politics
of student events
of general health service matters

Do you think that the Gazette covers events too much from a particular point of view? Would you like to see

More coverage of student affairs	Y N
More coverage of hospital affairs	Y N
More emphasis on the achievements of old Guy's people	Y N

Do you think that the tone of the Guy's Gazette is:

Too boring/staid Too flippant About right What tone?

Student events will of necessity increasingly be covered less from a Guy's perspective, and more from a UMDS one in future. Will this make the Gazette:

More interesting Less interesting No different

Are there any other aspects of the Gazette which you would like to comment upon? Please use the space below.

Protection is our middle name!

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GUY'S HOSPITAL GAZETTE
August 1991

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- Prof A H R Rowe — an appreciation
- The Future of the Trust — an interview with Dr Robin Stott
- Breast Cancer Research At Guy's — a continuing tradition of excellence

Guy's Rugby Football Club Raises £400 for Children's Unit

Guy's RFC Captain, Jeremy Worth, receives a certificate from Sylvia Sutton on behalf of the Evelina Children's Hospital Appeal. The Club, some of whose players wore their kit for the occasion collected £400 for the charity.

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Volume 105 Number 2414 August 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

One of the letters in this month's *Gazette* is from Prof G A D Haslewood, and in it he argues the importance of retaining basic science teaching on the Guy's campus. His letter had been prompted by the news that the BMS course was now split between the Guy's and St Thomas' sites. I wonder, therefore, how he and others will react to the news that Guy's, St Thomas' and King's College Hospitals may merge to form a single enormous school of medicine and dentistry, with its basic medical sciences section located at a point intermediate between all three campuses. If this proves feasible within the constraints of the building and of finance, it would produce a centre which would be excellent for research; this would be an advantage for the Medical School, since its research status was recently downgraded by the University Grants Council. However, would the move be so good for the education of students, especially at a time when the pre-clinical course is supposed to be developing a more clinically-orientated approach.

One could argue that the campuses are not separated by huge distances, and that students can commute between them to ensure that the course is fully integrated. But commuting is tiresome and expensive, and will erode students' affinity to their hospitals.

Previous correspondents have argued that it is the site of one's clinical training that dictates one's future allegiance to a hospital. At present, students undertake their clinical education predominantly at Guy's or St Thomas', but this system has been threatened by the recent changes in the NHS. The reforms have brought about the creation of the SE London Commissioning Agency. This Agency will be responsible for commissioning services for patients from Guy's, St Thomas' and King's College Hospitals. If all the hospitals are to survive then they must co-operate closely to ensure that they are not competing for the same patients, apparently there should be 'close co-operation between the two clinical schools to cope with the change that will *inevitably* (my emphasis) come in the pattern of clinical service provision'. Does this mean that UMDS will no longer be able to provide a comprehensive clinical education? Will all the liver problems go to King's, the kidneys to Guy's and the haemorrhoids to St Thomas'? These changes would lead to the extinction of that venerable beast known as The Guy's Man.

I am not suggesting that the NHS reforms and the reallocation of resources to hospitals outside of London should be halted just to ensure the future of the biennial dinner.

But the changes will destroy the traditional small, friendly, campus-based approach of London teaching hospitals and replace it with a faceless organisation scattered around south London. This may seem a very unappealing prospect to sixth-formers, and the range and calibre of applicants, and ultimately the new school itself, will suffer.

Dissent In The Ranks?

Dear Sir,

While I appreciate that it appears to be a little unfashionable nowadays, I must confess myself to be a believer in at least some of the principles and aims of trust status. A more patient orientated and team-spirited approach, to which we are exalted in the Trust News Bulletins, may just prove to be an answer to some of the woes of the NHS. However, it is then totally destructive and demoralizing to then be told, by certain of those busily expounding the virtues of trust status, that we 'the team' are underworked, overpaid and bored. Such comments can only destroy and drive away the very people that the NHS needs. Good leadership comes from knowing and inspiring your team, not insulting and belittling it.

Yours faithfully

Name and Address Supplied

In Defence of Guy's

Dear Sir,

Your remarks about preclinical training and the recently published articles concerning the mixed feelings of a former student about what went on in the 'sixties brings to attention the question whether Guy's should fight to retain its preclinical School. Does it matter, as one of your earlier correspondents suggested, where the preclinical training is done? Of course there are advantages to clinicians in having 'tame' scientists and their facilities within easy call. Is it not also an advantage to have ones' future doctors and dentists taught basic science in close contact with a hospital: daily the students can see the practice of what they are taught, apart from what can be laid on to demonstrate it for them? The old preclinical period did indeed induce the Guy's 'family' feeling mentioned by Dr Pitt-Payne. Perhaps with UMDS this has gone but, if not, retaining basic science teaching at Guy's might keep this too, to the benefit of our standards of loyalty and care.

There's more to education than acquiring facts and skills: there is an attitude of mind, a defence of civilised values passed on by precept and example and now well demonstrated by the splendid stand of our medical and dental professions against erosion of the Health Service.

Yours faithfully

G A D HASLEWOOD
28 Old Fort Rd
Shoreham-by-Sea
Sussex

The Summer Festival

Dear Sir,

It is with much sadness that I have seen the demise of Guy's Hospital Summer Festival over the past five years. This year's event was little more than a five-a-side football tournament with the accompanying music of the Plasma disco. Like myself, most of the competitors who had returned for the annual gathering were postgraduates. Why is it then that in the last two years

especially, the event has been so badly supported by the student body?

The Summer Festival has always taken place in the early part of June, a time when many exams to sit, but in the past this has not stopped many people from attending. The weather for the last two festivals has not been entirely conducive to a day out at Honor Oak Park, but the outside events this year were unaffected by rain. Perhaps the organisation of the events should be more widely publicised at an earlier stage in the year so that more teams would enter for events such as the five-a-side football, tennis, netball and rounders. This may encourage more people to attend bringing friends and family. Sadly, I feel that like many other events, support is sadly lacking from the student body.

I very much hope that my fears of the continuing decline of the Summer Festival are not correct and that with enthusiastic organisation, less apathy on behalf of the students, widespread publicity and perhaps a little more sunshine the event may return to its place as one of the major social functions of the year.

Yours faithfully,

ROBIN RUSSELL
Dept of Anaesthetics
Guy's Hospital

Shielding Students

Dear Sir,

Following a lengthy and most enjoyable sojourn in Eastbourne, I returned to my beloved *alma mater* looking forward to a three month psychiatry block.

On entering that sordid den of iniquity (known to Guy's *afficianados* as the Spit) I started to catch up with both the latest news from the Clubs Union and of other more intimate unions which had occurred since I had been away.

Imagine the dysphoria and altered mood state (I went to the introductory lecture course) I experienced on hearing the latest infallible edict to issue forth from the corridors of power in the Medical School.

I am, for those of you less informed than I, referring to the proposed new Guy's and St Thomas' shield.

I may be being dim, but why is it necessary to spend inordinate sums of money on designing a new combined shield when each of the hospitals already has an established heraldic line.

Surely now that the combined school has changed its name back from UMDS to Guys and St Thomas' Hospitals Medical School it would be highly inappropriate to have a new shield.

If a new shield was dreamed up would all the stained glass shields in the Medical School be replaced?

If this is to be the case, could I have first refusal on the carpet in the large committee room with its superb Guy's crest, as it would compliment the furniture in the living room of my flat.

Would the shield of our founder on the main Hospital gate be replaced by the new shield so that freshers could easily recognize that they were entering the grounds of the new combined school.

As a solution to what many of your readers will see as a somewhat controversial issue may I suggest that the Medical School saves its precious pennies for more deserving causes and keeps two separate shields as is the case at present. This system allows the combined school to be identi-

fied with the hospitals in which it is sited and provides a link with former years rather than a sudden discontinuity in the schools history, an idea that the Medical School seem to be promoting at present.

Yours faithfully,

STEVEN PRYKE
Boland House

Elective Awards

Dear Sir,

UMDS currently has approximately £10,000 available for distribution each year. Between 50 and 70% of eligible students apply for these awards annually, which vary in size from £100 to £500. In addition the School assessors can nominate students for additional monies from outside bodies. Students should be aware that the quality of their application significantly influences the final award given. As a large number of students are interviewed, the interview times are necessarily short. Students should therefore attend their interviews with full knowledge of their elective proposals if they wish serious consideration to be given to their application. If the number of applicants for School awards continues to increase then the School assessors reserve the right to short-list candidates on the basis of the quality of their written application forms. We hope that your readers find these points helpful.

Yours faithfully,

Dr J L HERZBERG
Dr G O'SULLIVAN
Clinical Advisers
UMDS

Addison Memorial Window

Dear Sir,

Dr Thomas Addison (1794–1860) was born in Longbenton, a community lying to the north-east of Newcastle. He received his primary education in St Bartholomew's Church School progressing to the Royal Grammar School in Newcastle and ultimately to Edinburgh University, where he received his medical education. From Edinburgh, he took up an appointment at Guy's Hospital, where he worked as a physician for 36 years. He died in 1860 and is buried in the graveyard of Lanercost Priory in Cumbria.

Dr Addison's greatest claim to fame was his description of a condition of the adrenal glands, resulting in a disease which now bears his name. He has, with some justification, been called the father of endocrinology, as a result of his work, and his name is known throughout the world. Addison's contributions to medicine were not confined to study of the adrenal glands. His name is eponymously associated with pernicious anaemia, which he was the first to describe. In addition, he contributed extensively to knowledge of skin disease.

In 1855, Dr Addison contributed the sum of £85 to a restoration fund at St Bartholomew's church in Longbenton and a window was installed above the altar in memory of his parents, who owned the local grocery shop. He was baptised in St Bartholomew's church. He was the largest benefactor to the appeal and, among other contributers of lesser amounts is listed Robert Stephenson, the son of George Stephenson.

The window was subsequently moved to a different site in the church and has now

fallen into a very poor state of repair. Damage by vandals in the latter part of 1990 has precipitated a need for action. This year the church is celebrating the bicentenary of its rebuilding and is already raising money to mark the event for a church extension to provide a chapel, choir vestry, office and to replace the central heating and renew the churchyard paths.

Consideration has been given to restoring the window but, in the view of experts, the glass has faded beyond hope of repair and it has been decided that the only viable alternative is to replace the window. To this end Mr L C Evetts MA, RCA has been commissioned to design and execute a new window, with due consideration to the original benefactor.

A number of ecclesiastical formalities have to be observed before installation can begin but it is hoped to be able to complete the work towards the end of 1991 or early in 1992. An inscription will be incorporated into the window to acknowledge Dr Addison's contribution to the church and it is intended to install a plaque nearby to commemorate the event. A scroll will be inscribed with the names of those who have contributed to the cost of replacing the window. It is hoped that there will be a formal consecration ceremony on completion of the work and that those who have contributed will be able to attend the service.

A fund has been opened to finance the cost of this undertaking and there is at present an anticipated need for some £5,000. This sum will cover the cost of the window, its installation and maintenance. Any money surplus to requirement will be invested to provide a scholarship, available to local young people who have achieved a place to study medicine in a medical school in the United Kingdom.

Yours sincerely,

DAVID MATHIAS
Consultant ENT Surgeon
27 Lindisfarne Rd
Newcastle upon Tyne
NE2 2HE

Guy's Hospital—250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.50, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital—250 Years, Guy's Gazette, Boland House, London SE1 9RT.

Bungy Bungle

Dear Sir,

Please may we use your letters pages to pass on our thanks to Neil Solomons for his interesting article on Bungy Jumping.

We were, like Neil, very worried that the figure 69 when written on his hand might have been read upside down resulting in a possibly fatal descent until one of our resident 69 experts pointed out that 69 upside down is the same as 69 downside up.

We of course held a meeting and, after much deliberation and several tests finally agreed that our expert was right.

We are now working on the figure 96 and will write to you with the results as soon as possible.

Yours faithfully,

Medical School Salaries Dept

Trauma Teaching At Guy's

Dear Sir,

I totally support your Passim's objective of better trauma teaching and more time in the accident departments of the UMDS for undergraduates (April *Gazette*). London is beset by a number of problems, one of which is the fragmented nature of trauma care in the capital. Until more hospitals combine, the care of the injured will be undertaken by many relatively small hospitals, with not all that great a through put. This problem is being addressed a little now.

The other problem is that the medical schools in London have traditionally not allowed much time or prominence to the teaching of trauma and accident and emergency medicine, or for that matter orthopaedic surgery either, in the last 20 years. In other universities in the United Kingdom, up to 2 months and sometimes 3 is spent on attachments to these disciplines. In the new clinical curriculum, at present being negotiated, it is possible that some correction of this will be obtained and I think then we will be able to set right the lack of tuition of undergraduates with regards to the management of injured patients.

Yours faithfully,

J D SPENCER
Senior Lecturer & Hon Consultant
Dept Orthopaedics
Guy's Hospital

Future of Guy's

The Guy's and Lewisham Trust is at risk of 'putting itself out of business' according to Peter Griffiths, the Trust chief executive, by completely redefining hospital care. The review of clinical services is likely to be much more radical than first envisaged. It was now clear that the review would examine transferring 'huge chunks' of hospital care into the community. He anticipates the Hospitals becoming much smaller, with fewer beds concentrating on specialist technical care.

Grand Fête At Guy's

The Guy's Kidney Patient Association are to hold a Grand Fête at Guy's on Saturday 7 September, from 12 noon to 5pm. A wide variety of stalls are planned, and visitors will be able to watch 200 volunteers abseil down the nearby Price Waterhouse building.

The event is part of the Association's £1m appeal—to date they have raised almost £750,000.

Waiting Lists

Mr Duncan Nichol, chief executive of the NHS, said that long-term waiting lists would virtually be eliminated by next summer. The number of patients waiting for more than two years had fallen by 40 per cent to 48,000. He conceded, however, that the cuts were partly due to taking names off the lists of people who no longer needed surgery.

Guillain-Barré Syndrome Support Group

On Friday 21 June Mrs Glenys Sanders, founder and secretary of the British Guillain-Barré Syndrome Support Group formally presented a Cobe Spectra Plasma Exchange Machine to Guy's Hospital. The device, which cost £34,000, was described by Richard Hughes, professor of neurology at Guy's, as the 'Rolls Royce of plasma exchange machines' and it will principally be used in the management of neuronal disorders, especially Guillain-Barré Syndrome. This syndrome, which affects about 1,000 people per year in the UK, can cause prolonged paralysis and nearly 25 per cent of cases require artificial ventilation. Scientific controlled trials have shown that plasma exchange treatment shortens the time to walk again by a month and halves the time for which artificial ventilation is required.

The machine has been in the intensive therapy unit since February and has proved very valuable—in fact I had seen it in use that morning on a patient with Guillain-Barré Syndrome.

Professor Hughes expressed his profound thanks and gratitude to the Support Group for their very generous donation.

Building At Guy's

A building grows like a child does—in uneven growth spurts. Roofing Philip Harris House is one high point in this growth pattern and 'topping-out' celebrates that particular achievement. 'Growing' the atria will be another.

The three covered courtyards are a major feature of Philip Harris House; at the moment they only show up as big rectangular concrete holes when viewed from above.

To make them lighter and more friendly the concrete will be covered in brick. Because Philip Harris House is joined to the Tower this cladding will also be applied to the east-facing wall of the Tower which then becomes the west wall of the first atrium. Again in the interests of harmony and balance the windows in the Tower between the ground and sixth floors will be replaced. This cannot be achieved without noise, dust, some disruption and consequent pain to the occupants of these areas.

When the brick cladding and windows are finished the atrium roof will be put in place and sloped to join the Tower wall to make a watertight union. Building the brick work will be the easy part; taking out existing windows and relocating new ones will be more disruptive.

A start has already been made in assessing how the work can be carried out with the minimum of nuisance and risk to both patients and staff. It is not expected that the work will be started until late August or early September by which time we hope to have consulted with all the people affected and also found routes for transporting in the necessary materials. Methods of work always have to be agreed between the Hospital and the builders and early anticipation of the difficulties and warnings to you help to alleviate your irritation.

You will be happy when you look out of the finished job; achieving it will be nasty.

Mr Boulter

Mr P S Boulter has been made President of the Royal College of Surgeons of Edinburgh. The presidents of both surgical colleges in the UK are now old Guy's men.

Mr F G Ellis

A vascular symposium to mark the retirement of Mr F G Ellis will be held in Robens Lecture Theatre, Guy's Tower, on Friday 13 September at 2.00 pm. All welcome.

Global AIDS Epidemic

The future spread of the global AIDS epidemic in the heterosexual population will make drug addict and homosexual cases almost irrelevant in numerical terms, the chief AIDS statistician of the WHO warned at the seventh international AIDS conference. Dr James Chin said that by the year 2000 around 90 per cent of global AIDS cases would be among heterosexuals.

He warned of increasing infection rates in Asia, and estimated that one in 40 men and women in sub-Saharan Africa carried the virus. Among women in the US aged 15–44 in 1987, AIDS caused virtually no deaths. By the mid-1990s it will be the third or fourth biggest killer of such women. In New York since 1988, AIDS has been the biggest cause of death in women aged 25–44.

Time For The Friends

This is the first of what we hope will be a regular contribution to *Guy's Gazette*. Our aim is to keep readers up to date with what The Friends are doing and why. We are giving more for the benefit of patients and staff than ever before. This is entirely due to the generosity of our members and supporters and over the next few months we will be telling you about the way the money is spent and the projects that The Friends have sponsored.

We don't intend to use the column to appeal to you for money—though of course we need money—we couldn't exist without it. Right now what we need—urgently—is your *time*.

Anyone who has been to Guys—either as a patient, a visitor, or as a member of staff, will know what a valuable service is provided by the *trolley shop*. The trolleys, which visit every ward at least once a week, sell as wide a range of goods as can be accommodated on a single trolley—toiletries, stationery, stamps, biscuits, sweets, drinks—all the little things that can make such a difference when you are confined to a hospital bed.

And there is the *library* which visits every ward once a week. A wide range of books and other reading material is available, supplied to The Friends by The Red Cross.

The other sign of The Friends—one which is visible to everyone—are the flowers that provide colour and cheer in the public areas of the hospital. The *flower shop* and *gift shop* gives a regular service to staff and visitors from its premises in the grounds and makes a significant contribution to The Friends' funds.

Have you ever wondered who organises all this? Who are the people who sell from the trolleys and arrange the flowers? In an institution the size of Guy's its easy for things to be taken for granted—but ask any patient if these services are important and necessary—the answer will be emphatically, yes. What the patient may not know, and even the staff may forget, is that these services are provided by volunteers—people who give a few hours a week—or even a few hours a month—to keep the services on the road.

Time has become so precious. In some ways it is more scarce and valuable than money. *Everyone* seems to be busy—working, running a home, bringing up a family, there seems to be less time to spare than ever before. But *not everyone* is living at such a pace. You may know someone who has a little time they could spare—you may be such a person yourself. Please don't hesitate—give us a call. Tell your friends about us. All we ask is that you be reasonably fit and available on a regular basis. If you think you can help please contact

Mrs A Clarke,
c/o, Mrs P Hutton,
The Friends of Guy's Hospital,
Guy's Hospital,
St Thomas Street,
London Bridge,
London,
SE1 9RT.

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Professor A H R Rowe

An appreciation

On 31 July 1991, Professor A H R Rowe retired as Dean of the Dental School, after almost 48 years association with Guy's.

Jack Rowe, as he is always known, was born in South Africa but almost immediately his family moved back to the United Kingdom and settled in Lymington where his father began to establish what soon became an extremely successful general dental practice.

Jack, the youngest of three boys, attended King Edward VI Grammar School in Southampton, prior to entering Guy's Hospital Dental School in 1943. He was an outstanding student in every respect, graduating BDS in 1948 with Honours in surgery, operative dental surgery, dental surgery, orthodontics and dental anatomy. During his studentship he was awarded the David Frank Student Prize for prosthetics in 1943 and the Prize in General Subjects in 1948.

Following a House Surgeon appointment, he undertook his National Service in the Royal Army Dental Corps, serving for a significant period in the prestigious appointment of Dental Officer at the Royal Military Academy at Sandhurst.

After leaving the Army, Jack Rowe began a 13 year period as a half-time teacher in the department of Conservative Dental Surgery at Guy's, first as a teaching registrar but for the last four years as half-time assistant to Professor W E Herbert, in the grade of Senior Lecturer with Consultant status. For the remainder of his time he was in general dental practice with his friend and colleague David Robinson. It was during this period, in 1954, that he obtained the FDS of the Royal College of Surgeons of England, and began his long-term involvement in endodontic research, which did much to bring about the metamorphosis of endodontics from an art to a science. This valuable and pioneer work was put together in the form of a thesis, for which in 1965, he was awarded the degree of MDS of the University of London. This degree ranks in London as a Higher Doctorate and he was the first Guy's man to receive it.

In 1963 he gave up practice and came to Guy's as a full-time Senior Lecturer, and when Professor Herbert retired in 1967, he became Head of Department and was appointed to the established University Readership in Conservative Dentistry. The present title of Professor of Conservative Dentistry was conferred in 1971 by the University of London.

It was during this period that he began to become increasingly involved in the wider aspects of dental education. In the University he held office on the Board of Studies in Dentistry culminating in his 3 years as Chairman during that extremely difficult period when 'The Royal' was closed and the school merged with UMDS. Additionally, he served as dental representative at Senate, the Joint Medical Advisory Committee, the Academic Advisory Board in Medicine and the Standing Sub-Committee in Medicine of the Academic Council.

In 1980 he was elected to the Board of Faculty of the Royal College of Surgeons of England and in 1988 was re-elected to serve for a second term. He was Vice Dean in 1987–8, Chairman of the Examination Committee in 1986/87 and 1988/89, South East Thames Regional Advisor for the period 1983–88 and member of the SAC on Restorative Dentistry from 1979 until 1985.

In 1974 he began a 10 year period as a member of the Dental Sub-Committee of the University Grants Committee, during which time the difficulties due to Government restrictions in University funding began to take effect.

Through almost all his professional life, Jack Rowe has been concerned with the Medical Defence Union, first as its part-time Dental Secretary but later as a member and more recently as Chairman, of the Dental Committee. He is also a member of the Council of the MDU and has served on numerable of the committees and sub-committees.

Other outside commitments which he has undertaken include a directorship of the Medical Sickness Society, External Assessor for the University of Malaya, Consultant Advisor to various industrial companies with dental interests, member of the Lewisham and Southwark Health Authority and member of the Special Health Authority and Governor of the Eastman Dental Hospital.

Amongst the professional associations, he has held office in the BDA, is a founder member and former President of the British Endodontic Society and one time editor of its journal. He was involved in the formation of the British Society for Restorative Dentistry, was its Treasurer for 10 years before becoming its President for the year 1978–9.

Jack Rowe is a widely sought after examiner who, apart from his examinership, including Chairman of Examiners, in the University of London, has been called upon to serve at the Royal College of Surgeons, the Universities of Birmingham, Dundee, Manchester, Wales, Belfast, Newcastle-upon-Tyne and Edinburgh, as well as overseas Universities in Lagos, Malta, Nairobi, Malaysia, Dublin, Sri Lanka and Singapore.

His outside commitments are never allowed to displace his responsibilities at Guy's, and apart from being Head of a very large Department, he has served on many committees which include the Finance Committee, the Council of Governors and the Health Authority.

However, it is as Dean of the Dental School that he has made such an important contribution. In every respect he has been a model Dean, indefatigable in fighting the Dental School corner in the competition for funding and resources. He states his case with clarity, a deep understanding of the overall problems but above all, with impeccable standards of integrity. Colleagues and students hold him in highest regard and affection, always knowing that whatever the problem, he will discuss and face it quietly and equably, with sympathy and understanding.

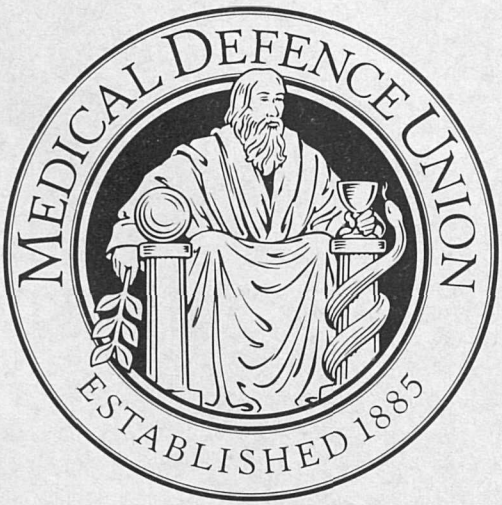
He is a boundless supporter of the social and cultural life and in all these activities he is invariably accompanied by his wife, Pat, who shares with him a deep love for Guy's, its traditions and all it stands for.

Jack Rowe will be a hard person to follow as Dean, Head of Department and in all the other activities in which he has been involved.

His colleagues and many generations of Guy's men and women whom he taught will wish him a long and happy retirement.

MNN

THE MEDICAL DEFENCE UNION



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The Future of the Trust

An interview with its first medical director

I recently talked to Dr Robin Stott, Chairman of the Unit Management Board at Lewisham Hospital and the first medical director of the Guy's and Lewisham Trust.

Dr Stott, the 'internal market' and the split between purchaser and provider has advantages for the purchaser in terms of efficiency and choice of high quality service; do you think that there will be many advantages for the provider in the new system?

'The answer is that nobody knows. This split is not a feature specific to trusts—this will apply across the whole service regardless of whether provider units are directly managed or self-governing trusts. Any benefit that might emerge should accrue across the whole service—but I think that these benefits are not clear, certainly not for the providers. Looking specifically at trust status there will be greater autonomy for the trust which will work closely with the purchaser to try to met the health needs of the local community.'

But aside from management, in some ways there will be less autonomy for the provider units than now, given that they will be working within an explicitly demand-led system, which will direct their workload.

'Absolutely, I wasn't suggesting that there will be more autonomy than there is now, but there will certainly be more autonomy than there will be for directly managed units. We specifically value the self-reliance that trust status gives us. This will better enable us to meet the demands of our purchasers, and to develop new methods of providing relevant high quality health care.'

Are Guy's and Lewisham hospitals in a particularly strong position to take up trust status; and to what extent does this relate to previous management innovations at Guy's such as the resource management initiative (RMI)?

'The first part of your question is clear but the follow-up is not. The RMI does not specifically relate to trust status.'

I'm not exactly clear what the RMI involves.

'Well, you're not alone in that. Traditionally hospital work has been generated by consultants but it has been organised separately from them by administrators. The RMI emphasises that it is essential to incorporate those responsible for spending the money into the management structure, and looks to change the

Work on building Philip Harris House continues. The building is estimated to cost £115 million and is due to open in Autumn 1993. Its completion will mark the end of the third phase of the rebuilding of Guy's Hospital.

organisation of hospitals to ensure this. In practice this has also focussed on collecting information to assess how hospitals are working. My view is that the information needs should be clinically driven. A basic need is that every patient who comes through the hospital gates has a diagnosis attached to them—you may think that that's very straightforward, but I can assure you that in a lot of hospitals this hasn't happened.'

But doesn't this information gathering facilitate the pricing of patients admissions to hospitals and therefore the cost of individual procedures, which will gradually become a feature of the new contracts.

'The RMI is not a costing procedure. It is a clinician-led system which looks at ways of running hospitals effectively to generate quality health care. The new technology supports this but costing emerges purely as an epiphenomenon. If we use information technology purely as a costing procedure then we do so at our peril. It has happened in some centres and it simply hasn't worked.'

But isn't it mainly the task of procedures like medical audit to look at outcomes and efficiency from a clinical standpoint?

'Yes, but we need to consider a wider view in the organisation of hospitals which must include everything from catering and cleaning, to the heat and light consumed by the hospital in each episode of patient care. There is a substantial difference in emphasis between a manager coming along and asking how much a patient has cost the hospital and a clinician working out what it costs the hospital to manage a patient with an MI. It shouldn't happen, but inevitably there is a tension between clinician and managerial-led analysis of hospital costs.'

How important will the costing of procedures be in the new contracts?

'The notion that there will be charges for individual cases coming through hospitals is not one that we will arrive at in the short term. Elements of individual costing may emerge with the cost and volume contracts, in which there will be incremental payments for cases seen over a pre-set minimum, but at present contracts will be all calculated on standard costs set by the Department of Health—very few hospitals are in a position to work out individual case costs.'

You're going to be the only clinician who will be an executive member of the trust board, in your position as medical director. What exactly will this job involve?

'I haven't got a specific job description as yet, but I see my work in terms of trying to think of innovative ways to provide quality health care. To digress, we feel that nowhere in the world has an inner-city hospital been shown to provide a decent quality of health care, to the local and wider population, at a price which the government cares to pay. The Trust's central purpose is to drive towards that goal. This is going to involve, with the commissioning bodies, breaking down the barriers between hospitals and the local community. My work will involve ensuring the clinical relevance of procedures such as the RMI. Additionally I will be taking corporate decisions as a member of the trust board—this will be very much on broad policy areas. Day-to-day decision making will be devolved downwards.'

Do you see yourself as a representative of clinicians' opinion on the trust board?

'No, I don't. To the extent that I'm in day-to-day contact with clinicians my opinions will be partly shaped by them. But, beyond that I do not see myself as a representative on the board with a mandate from clinicians. The trust board will sensibly be very much looking to clinicians, the strongest group in the new trust, to provide ideas in its policy making, but I don't specifically see myself as their spokesman.'

How do you see doctors' everyday work and their position changing in the trust?

'It's difficult to say. If we are going to radically change the delivery of health care to the community then it's inevitable that this is going to lead to some change in work style. There certainly ought to be more involvement of doctors in the use of the information technology. All doctors qualifying now should be computer literate whether they work in trusts or not. Our new autonomy will allow us to be much more adventurous in areas like this—I see no reason why a step such as having all patients records on computer shouldn't be possible within the next five years. In a wider context there will be no radical departures in doctor's pay and conditions in the trust: contracts formed before the trust was set up will be honoured and beyond that we will be sticking to nationally agreed pay scales.'

Do you welcome the introduction of outcome measures into the new contracts?

'A much closer look at outcomes is certainly needed. To take an example from the US: the amount of carotid artery surgery done varies between areas by about four times, and yet there is no good evidence to show that any carotid artery work is worthwhile. The results of effectiveness studies will direct us to concentrate on specific areas.'

Do you see the Trust setting itself up as specialist in particular services which will be offered cheaply and will attract patients from other units?

'In the short term there is no scope for Guy's to become a specialist in, say hip replacements, because of the use of block contracts and the steady state approach demanded in the first year, but beyond that we will certainly resist any moves into widespread fee-for-service contracts because of the bureaucratic explosion that that will entail. In the period after this, in which there will be more de-regulation we will be looking first and foremost at serving the local community and seizing the opportunity afforded by our independence to use new approaches to make inner-city hospitals work.'

Dr Stott, thank you very much.

HM

Breast Cancer Research At Guy's

A continuing tradition

Origins (1936–1970)

The development of medical oncology in British hospitals has had a variety of origins, often emerging from departments of haematology. At Guy's, the specialty has evolved from our long-standing interest in breast cancer. In 1936, Mr Hedley Atkins (later to become the Medical School's first Professor of Surgery, President of the Royal College of Surgeons and Knight) founded the 'mastitis clinic'. Progress was slow during the war years, but with peace and the appointment of John Hayward to the staff of the Hospital, work on breast cancer began to flourish. John Hayward's aim was to ensure that clinical practice was conducted within a highly organised structure so that a maximum amount of information could be obtained about the disease. Patients were treated, when at all possible, within prospective randomised clinical trials. This approach has been the surest way to identify with confidence when progress is or is not being made in the treatment of cancer. Indeed, Atkins and Hayward are to be credited with performing the first ever clinical trials in cancer, a method which has dominated clinical cancer research in the last three decades.

The early trials concentrated on surgical approaches to the treatment of breast cancer, both in early and advanced disease. For early disease, the safety of breast conserving treatment was studied, while for advanced disease, methods of ablative endocrine surgery were investigated. These latter procedures were found to be effective in only a proportion of patients and Hayward sought predictive tests to identify which patients were likely to benefit and so avoid ineffective treatment in others. His approach was to study the endocrinology of patients in collaboration with Dr R D Bulbrook of the Imperial Cancer Research Fund laboratories. In the 1950's, this started one of the most remarkable and successful collaborations in breast cancer research which lasted over 30 years. Discriminant tests were developed to guide the selection of patients for major endocrine surgery. Although these treatments have now been replaced by advances in drug development, these tests played an important role in the management of this disease. Of contemporary importance to the control of

breast cancer are the findings from Bulbrook's and Hayward's unique Guernsey experiment which ran for a quarter of a century. It established endocrine profiles predictive of which women are at high risk of developing breast cancer, and validated mammographic patterns indicative of high risk. These findings are now being applied to breast cancer screening and they also provide a basis for the national breast cancer prevention trial.

1970–1985

In 1970, this work into breast cancer was marked by the establishment, at Guy's Hospital, of the first extramural unit of the Imperial Cancer Research Fund (ICRF), with John Hayward as its director. At this time, the large service given to patients by the Unit was recognised by the building of a purpose-designed in-patient department at New Cross Hospital from Health Service resources. This fine 36-bedded unit was an example of the National Health Service at its very best and we were all saddened when it was lost with the closure of New Cross Hospital in 1986 during the Health Service cuts. It had been named the Hedley Atkins Unit in 1975, a commemoration which has been transferred to our present ward in New Guy's House.

Figure 1 The Hedley Atkins Unit at New Cross Hospital. Now a home for elderly demented patients

A significant development in the early 1970's was the increasing use of cytotoxic drugs and new hormonal agents against breast cancer. This led to the appointment of the author as the Hospital's first consultant in medical oncology who, with Doctor R K Knight and Professor J R Trounce, established the Medical Oncology Clinic. This now provides a full-time base not only for the treatment of breast cancer, but also a variety of other tumours. In the early 1970's, the Unit also appointed a full-time consultant pathologist, Doctor Rosemary Millis. A dedicated laboratory within the Unit has been fundamental to providing a sound biological basis for our clinical research programme and has enabled the development of immunohistochemistry, steroid receptor biochemistry and molecular biology.

From 1970–1985, the Imperial Cancer Research Fund's commitment to research at the Hospital increased steadily from an establishment of 6 to 60 workers. On the retirement of Mr Hayward in 1985, the ICRF endowed the first Chair of Clinical Oncology in UMDS and set aside funds for the department's future in Philip Harris House.

Current Research

Over 80 projects in the Unit are described in the ICRF Scientific Report for 1990 and so only the briefest of summaries can be given here.

We have shown that early breast cancer can be treated effectively and safely without the trauma of mastectomy in many patients; the cosmetic results are excellent. The technique entails tumour excision, axillary clearance and radiotherapy by a combination of iridium implantation and external beam treatment. This takes several weeks. We are, therefore, exploring the use of higher dose rate delivery isotopes for the interstitial treatment (brachytherapy) in order to reduce treatment times to days or hours and, possibly, obviate the need for external beam radiotherapy. This would make breast conserving treatment available to more patients. At present, these methods are unsatisfactory for patients with larger tumours and so new research is testing the use of primary chemotherapy for these cancers to reduce their size sufficiently to enable breast preserving treatment to be carried out.

Despite radical treatment, many patients relapse with locally recurrent disease or distant metastases. This is from the growth of occult micrometastases present at the time of initial diagnosis. We and others have shown that the risk of relapse can be reduced significantly by giving chemotherapy or endocrine treatment as part of the primary management—adjuvant systemic therapy. The probability of relapse varies greatly and depends upon such factors as the extent of lymph node involvement, histological characteristics, tumour size and cell proliferative activity which we measure by flow cytometry. Hence, to select patients rationally

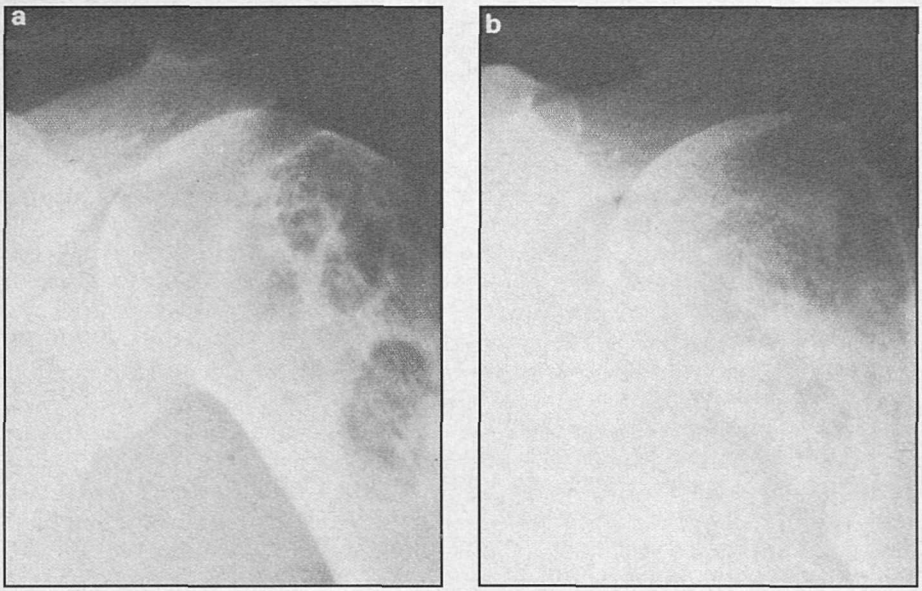

Figure 2 Plain radiographs of the left iliac crest in a patient with metastatic breast cancer (a) before and (b) 6 months after treatment with APD (a diphosphonate). The lytic lesion has undergone sclerosis.

for adjuvant treatment, we depend on careful laboratory evaluation of an individual patient's disease. For example, some patients will be found to have a prognosis no different from the normal population and so can safely be spared the rigours of additional treatment.

For metastatic disease, treatment is palliative rather than curative in intent. Nevertheless, good control of disease can often be achieved, sometimes for several, even many, years, with the use of radiotherapy, endocrine treatment or cytotoxic chemotherapy. We have undertaken the development of numerous new agents and this work continues. Older toxic treatments are being replaced by new well-tolerated ones so that living with cancer is gradually becoming a less onerous ordeal for patients. Structured quality of life assessments are built into all these drug development projects.

At present, we are particularly interested in the anthracycline drugs. These have high activity against breast cancer, but, being metabolished in the liver, they are difficult and toxic to use in patients with metastases at this site. Phar-

macokinetic studies in the Unit are providing important information on the handling of these drugs and leading to their more effective use.

A common problem with cytotoxic drugs is bone marrow suppression which limits the doses that can be given. If higher doses could be given safely, cancer chemotherapy could be more effective. The recent availability of haemopoietic growth factors, in particular granulocyte colony stimulating factor, facilitates high dose treatment, an approach being actively pursued in the Unit. If this research is successful, it will have application not only in advanced disease, but also as adjuvant treatment in patients with early disease at high risk of recurrence.

Bone metastases are common in breast cancer leading to pain, disability, fracture, hypercalcaemia and neurological complicatons. The destructive effects of these lesions are mediated largely by osteoclasts stimulated by tumour-derived growth factors. We have been active in the development of a class of osteoclast inhibiting drugs called bisphosphonates, specifically pamidronate. Our work has demonstrated the effectiveness of this agent against hypercalcaemia, for which it is now the agent of choice, and its ability to reverse osteolytic disease. Work on this drug continues. A further new approach to bone metastases is the adminstration of bone-seeking beta-emitting isotopes as a method of internal irradiation.

The future

We shall continue this broad-based research into breast cancer and its treatment, always looking for new approaches and testing them clinically. With our new laboratories in Philip Harris House there will be a further increase in the scientific staff to add depth to the research programme by working on the molecular genetic basis of breast cancer. This line of investigation is the one most likely to increase our understanding of cancer providing more effective ways to prevent and treat the disease. Even now our collaborative work with the ICRF laboratories has identified antigenic peculiarities of the cancer cell surface. This has led to the planning of an exciting programme of active immunotherapy for patients. Underpinning this work is research into the immunology of patients with breast cancer which we hope will also elucidate the mechanisms by which psychosocial stress adversely affects the clinical course of the disease. This too should develop effective interventions in the future and, hopefully, preventative measures against the disease.

We are proud of our heritage in breast cancer research at Guy's and the scientific principles established by our founders will continue to guide our work into the future.

Professor R D Rubens

Life In Wartime Pembury

A time of dances, bridge and bombs

Mr C Lambrinudi reported to me, looking as handsome and debonair as ever, to the joy of the Nurses. Lambri was a great asset to the staff and popular with everybody. He had an endearing habit of turning to Sister and saying, 'I think this patient is going to faint. Could you bring some brandy please?' A small quantity of brandy was held on the ward for such an emergency. As in the Royal Naval hospitals it was entered under 'medical comforts' and could be prescribed! A small tot of brandy was brought and Lambri used to drink it himself saying, after all, his needs were greater than the patient's.

He had a permit to travel anywhere in Kent and I also had a similar pass, although I never knew why, and on occasion he would be asked to visit another hospital. He often asked me to accompany him and it was a relief for me to get away for an hour or two! We were driven in a large American saloon by a most attractive American woman driver but we found very early that these big cars with such soft springs were sick-making in the extreme, and we used to crowd into the front bench type seat. Lambri always chose to sit next to the attractive girl driving us!

A very popular member of the Guy's Staff at Pembury was Archie Marston. He organised the anaesthetics for the theatres, was always cheerful and was superb at his specialty—nothing was too difficult for him. I remembered him well from my Guy's days. The senior anaesthetist then was Sir Francis Shipway, who invented the apparatus which bears his name. It was a godsend to E A Scott, another Guy's anaesthetist, who used to put the patient under, link him up to the 'Shipway', and then go out onto the theatre balcony and chain smoke! He maintained that he could hear any change in the patient's breathing but students were constantly being sent to call him back to the patient.

John Carter Braine, the Guy's Radio-therapist, was seconded to Pembury and we were delighted to see him. He brought with him his own personal quantity of Radium and that caused us some problems. What would happen if a bomb hit and scattered it around the countryside? We thought of the Hospital well—thirty feet deep. Our engineer devised a container, fixed to a wire passing down the well, which could be raised and lowered quite quickly. The idea was that on an alert the radium needles were to be removed from the patient, placed in a heavy lead lined carrier, taken to the well, transferred to the carrier and lowered thirty

feet. Well. It was a good idea but quite impractical. We finally had two huge steel cylinders made. The radium needles were now surrounded by three inches of steel and, if a bomb hit it, it would remain intact. We never used either of them!

John Carter Braine brought a therapy machine to Pembury and, in fact, started the Department which exists today. It brought hope to many unhappy people who felt that such treatment would cease during the war.

My old chief Philip Turner was transferred to Pembury and I was delighted to see him. He was a very old friend and became 'Uncle Philip' to my children. I must add that he seemed to have a bevy of beautiful young girls who were all nieces! He had been such a quiet and reserved person that I was surprised to find other facets to his character. He was a keen and excellent dancer and a veritable 'ball of fire' at the nurses' dances! He was a wonderful surgeon, careful and precise and a splendid example for young registrars and house officers.

Of the Guy's nursing staff others have written, but I particularly remember Sister Opie, Miss Marriot, the Assistant Matron whom I cheerfully called 'Public Menace No 1', and Miss Addison. Jean was a very pretty girl and danced divinely at the Christmas dance, I remember.

Life was very pleasant during those early days and we had dances and concerts, which the young Trethowans arranged. It is amusing to recall that William Trethowan (later Sir William) became a distinguished psychiatrist and his brother, John, an ENT surgeon in Tunbridge Wells. When Treth died his widow took up medicine and I remember her very well during the War, as a very courageous and charming person.

But our halcyon days were soon over and with the reverses in France we were called upon to house, temporarily, displaced persons, mostly old, from the Dover area, I remember converted buses driving into the Hospital gates and our team of porters, under Bateup, an ex-RSM, lifting hundreds of green stretchers or helping aged people into the wards. It was a Herculean task and I never knew how they managed it, especially as those same porters put them into Green Line buses the next day for their journey to the safety of Wales. May 1941. Dunkirk: we admitted a large number of patients, of all nationalities. One or two were exceptional.

I was called to a private room in the medical ward where a man had been admitted wearing a magnificent but unidentifiable uniform. I later discovered that was a Belgian Gendarme—very wet but unharmed. We had a very wet Zouave—how he got mixed up in the retreat I have no idea and a Russian soldier, also uninjured; he was a complete peasant, and had never seen a water tap nor a toilet before. How does one explain the uses of such things if one has no Russian? We never did.

More seriously we had a group of French sailors, excellent fellows, who had

been rescued at Dunkirk, taken aboard a destroyer and were on their way to England when the ship hit a mine. The men were standing on the deck and the explosion caused fractures of their femurs, tibiae and fibulae.

One French soldier, recovering from an anaesthetic, kept shouting 'Où est mon baton?' It transpired that he had a murderous heavy stick with which he intended to slay Germans. He quietened down when he was given something to hold.

They also brought with them every conceivable kind of weapon. We had to send Bateup, who knew about such things, to collect them and he ended up with buckets of ammunition, guns, pistols and revolvers, hand grenades, knives—we had to get the soldiers to take it away, but not before I had selected a small automatic and two clips of ammunition. It was a dainty little weapon and I don't know what I intended to do with it but I put it in a locked drawer in my desk. I suppose I still remembered the First World War and maintained a hatred for Germans so, if I was attacked I thought I'd try to take a few of them with me. I had been instructed to stay at my post if we were invaded and run the Hospital for the many expected casualties from both sides; an unattractive prospect. My wife and family were miles away in Chipping Campden!

Although we were in 'Bomb Alley' the Hospital was never hit by anything substantial. We had lots of incendiary bombs, many failed to go off because they were filled with sand. Bateup opened one for me and inside there was a small bit of paper with 'from Czechoslovakia' written on it—those brave fellows had duped the Germans at no small risk! Sticks of bombs did come down, many jettisoned by escaping bombers, but not on us; bits and pieces of planes destroyed in the air did present a possible hazard.

Of sticks of bombs; my wife and I were playing bridge with friends in Tunbridge Wells, when the siren sounded and later a stick of bombs came down. We heard the first bang and promptly dived under the table. Then another bang and another louder explosion, then a pause and a final bang further away. We crawled out from under the table and roared with laughter when we looked at the bridge table under which we had instinctively dived for protection. It had a green baize cover over thin plywood. We drove home after the 'all clear'.

Later we were told that the unexploded bomb had sunk deep into our friends garden—we had driven away within a few yards of it that evening. I certainly wouldn't be recording this if it had exploded!

E D Y Grasby

to be continued

Preparing To Meet Patients

The summer of '67

The nightmare of the second MB quickly faded and the pre-clinical course beckoned. The bones of this grounding prior to going on the wards took place in a large well-lit room which must have been on the fourth floor of outpatients—or thereabouts. Dr R K Knight would be the Clinical Tutor and he together with *Hutchinson's Clinical Methods*, would be our guardian and guide for the next few weeks. There was also a bacteriology course that appeared to take place deep within the bowels of the Medical School most afternoons. There was also quite a decent pin-ball machine in the local King's Head; it took the old threepenny bits and we wiled away many a happy hour on the thing. The bacteriology lecture usually commenced at 2pm and the King's Head shut at 3pm. Obviously there was something of a conflict of interest here; one which we managed to resolve but at some cost to our knowledge of bacteriology. Just after 3pm we would weave our way back to the lecture which had now become a demonstration. A brief and somewhat enebriated squint down a few microscopes sufficed and then it was time to go home—or whatever. I don't know how we managed to get away with it, but we did—and a good time was had by all. They were halcyon days.

Bob Knight taught us how to examine patients and he did this so well that it has stuck with me ever since. A couple of years back an old contemporary found himself attending me for an insurance medical and commented that the examination I'd performed was exactly as Bob Knight said it should be done.

Taking a history seemed to be something of a feat of memory and my early attempts at it were fraught with difficulty to such an extent that I had to have a crib-sheet in my inside pocket so I'd know what questions to ask the patient next. The list ran something like this: appetite, sleep, bowels, waterworks, periods. We were told to stick to the gentle stuff at first and only ask the really awkward questions when the patient knew us a bit better.

The biggest hurdle for me personally was my first rectal examination—and I don't care who knows it! The fellow who said it that if you don't put your finger in, then you'll put your foot in may have had a point at the time when he said it.

Of course, there were blasé students in my year who insisted there was nothing to it—and for them there probably wasn't but for a delicate soul like me the thought of marching up to a complete stranger and asking to stick a finger up their bottom seemed very strange—I mean, nothing like that had ever happened at school; not even Epsom College! The ramifications of this kind of topic know no end and I would like to see this kind of medieval humiliation ended.

We were expected to look like doctors and this—for Bob Knight—meant short fingernails, clean hands, well-cut hair, and a decent set of clothes. These maxims still hold good for me. Doctors who smell of drink with nicotine-stained fingers need a second glance.

There was a pathology course too and the essence of the subject went in somehow and all that stuff about *rubor, calor,* and *dolor* has stuck in there somewhere and is trundled out especially when I am dealing with a severe case of *ossilans plumbi.* I remember that we went through it with a condition called 'lobar pneumonia' and then got taken to see a case on the wards. At that time I was incapable of speaking anything but second world war slang so one of my early encounters went something like this:

Q: And what has been the matter with you?

A: I've 'ad double pneumonia.

Q: Jolly good show! (gulp) What I mean is—jolly *bad* show, what?

The stethoscope seemed to matter a great deal and I had one with lots of curly ear pieces and much red rubber. I suppose it could have doubled up as an enema syringe but I was very proud of it and the ear pieces protruded from my pocket especially on the train home. In all the years I commuted no one took a bit of notice.

I never heard a lot down it. All those noises we were supposed to hear were something of a mystery. The various murmurs, that opening snap, this mid-systolic murmur, that protodiastolic gallop rhythm. These days I'm amazed at what I can hear and often—to put the patients at their ease—I might say: 'You know—on a good day I can hear Jimmy Young on Radio Two.' As often as not such comments do nothing for 'them' but they cheer me up no end!

The process of learning appears to have happened quite unconsciously as far as I am concerned. My fading memory has deemed that this should be so. Like learning to read, my way with patients came to me—as it did to the hundreds of others in the years before and since. The processes whereby this happened appear to have depended on the Clinical Tutor; and he is regarded with much affection—whoever he may have been!

JHP-P

Mr David London

Many Guy's graduates and people at Guy's will have learned with great regret of the death of David London LDS, RCS(Eng) on 10 April 1991.

David was well known to generations of students at Guy's and Cardiff at which schools he taught Conservative Dentistry for many years.

He qualified at Guy's in 1951 after an excellent record as an undergraduate. He was appointed a house surgeon and on completion of this post he did his National Service in the Army. In 1954 he was appointed a 6-session demonstrator and later a half-time lecturer in the Department of Conservative Dental Surgery. He built up a practice in Croydon where he would often be at work late in the evening. He became a full-time lecturer from October 1963 until September 1967. During his time at Guy's he proved himself to be a first class teacher. He conducted many Phantom Head classes and was a most conscientious teacher in the clinic. He left Guy's to take up a similar post in the Conservation Department in Cardiff. After several years he decided to go into Dental Practice and worked in a Guy's practice in Guildford until his final illness.

David found time for many outside activities including a very keen interest in the British Endodontic Society. He served on the Council of the Society for a number of years and he took on the very onerous task of Secretary from 1973 to 1977. He arranged many successful meetings and in 1977 was made President, a position he filled with great distinction.

As well as running a successful practice in Guildford he was very active in the local church, where he was Churchwarden and an Elder. The number of people attending the Memorial Service was a great tribute to him.

David was a remarkable man, time did not seem to matter; the priority was to complete the job in hand to the highest possible standard; this trait sometimes dismayed his colleagues but David would not be deterred. He was universally popular and was never known to utter an unkind word about colleagues or students.

He was devoted to his family and to them and especially to Daphne, his wife, we send our heartfelt sympathy and hope they will gain solace from the knowledge that David was held in such high regard by so many people.

Dr Charles Marshall

Dr C W Marshall died peacefully in a nursing home in Budleigh Salterton on Wednesday June 12, 1991, after a short illness.

Born in Cheltenham in 1903 Charles Marshall came to Guy's in 1921 from Malvern College where he had taken his first MB. He was thus able to qualify in April 1926, four and a half years later. He then served as HS in the Orthopaedic and GU Departments and as Obstetric Resident. Elected President of the Residents in 1927 he had the privilege of representing them at the Bright Centenary celebrations. He was also the last President to take the then traditional Residents' Bus to the

Derby. The Nomads found his height useful in the 'line-outs' and he was a founder member of the United Hospitals Sailing Club.

Eighteen months at what was then called the Queen's Hospital for Children in Hackney followed; here he met his future wife, Helen Browne, a Mary's graduate. There were six residents there, and theirs was the fifth pairing in three years. Next came a spell at the St Mary, Islington (now Whittington) Hospital where he was in post when the LCC took over from the local Board of Guardians.

Having proceeded MD in 1930 he married and went into general practice, first as an assistant in Dorset and then in a partnership in Exeter. Here he held office in the BMA, Medical Society and Local Medical Committee; he was also County Medical Officer to the British Red Cross Society, and held a churchwardenship.

The 'Exeter Blitz' found him serving as MO to a First Aid Post; subsequently joining the RAMC, he served in North Africa and Italy, where he was mentioned in Despatches.

In his retirement he and his second wife, Marjorie, took up croquet at the Budleigh Salterton Club and they became familiar figures at tournaments in the south of England. They were founder members, and he was the first President, of the new Exeter Croquet Club.

He is survived by his wife, three children and six grandchildren and by step-children and grandchildren.

PJCM

Dr Ciaran Barry

The death has occurred in Dublin of Dr Ciaran Barry, who was president of the Royal College of Physicians of Ireland, consultant in rheumatology and rehabilitation at the Mater Hospital and medical director of the Central Remedial Clinic. He was 63 years old.

The Royal College of Physicians of Ireland said in a statement that Dr Barry brought great expertise to the presidency and forged strong international links, including his appointment as Fellow of the American College of Physicians last year.

Concerts and the restoration of paintings and of the college's library were commenced under his direction, the college stated. Faculties were encouraged to produce reports on major aspects of health care and educational programmes overseas were put in train. 'All aspects of the college's life were challenged to produce their best consistency under his direction,' the college said.

Previous to his election as president in 1989, Dr Barry spent 14 years as registrar of the college.

He was educated at national schools at Frosses and Dunkineely, Co Donegal, followed by Blackrock College, Dublin, and University College, Dublin medical school. During 1960–64 he was registrar/senior registrar in Physical Medicine at Guy's Hospital, London. He received his doctorate in physical medicine (DPhysMed) in London in 1962.

In 1964 he became both medical director of the Central Remedial Clinic in Clontarf,

Dublin, and consultant in rheumatology and rehabilitation at the Mater Hospital, Dublin, and held these positions until his death. He held teaching affiliations to UCD, Trinity College and the Royal College of Surgeons in Ireland. From 1964 to 1987 he was also a consultant at the Incorporated Orthopaedic Hospital of Ireland.

He has been an executive committee member of the International Cerebral Palsy Society since 1981 and from 1983 to 1987 was president of the International Cerebral Palsy Society. Since 1980 he has been a director of the Irish National Rehabilitation Board. He was a founder member in 1972 of the Irish Association of Rheumatology and Rehabilitation, of which he became president (1985–87).

He was also a founder member (1976) of the National Association of Boards of Management of Special Schools in Ireland and was its president in 1978/80.

In 1987, he was elected a fellow of the American Academy for Cerebral Palsy and Developmental Medicine and was also appointed that year to the international affairs committee of the American Academy for Cerebral Palsy and Developmental Medicine (AACPDM).

In 1988, he was appointed chairman of the conjoint board of the Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland.

Dr Barry had been ill recently but had made a substantial recovery before his sudden death on Saturday.

He is survived by his wife Adrienne and his children Marc (20) and Jane (17).

Dr William Dobson-Smyth

William Evelyn Dobson-Smyth, the second son of a General Practitioner, was born on February 4 1921 and spent his childhood in Torquay. He was educated at Clifton College, Bristol, (1930–1935) and Bryanston School, Blandford (1935–1939), and was accepted by Guy's Hospital Medical School. His training was interrupted by the Second World War during which time he flew Spitfires as a Flight Lieutenant in the RAF.

After the war he completed his medical training, qualifying in 1951, undertook various house jobs and joined the Hanham Practice in 1953, with which he stayed until his retirement in 1985.

During his period as a General Practitioner he was an active member of the Gloucester and Bristol LMC (1960–1970), Clinical Tutor to Frenchay Hospital (1970–1977) and the GP Member of the Frenchay District Medical Team (1981–1985).

In 1970 he presented an important paper to the Royal Society of Health in Eastbourne entitled *Teamwork in Community Care* and produced a Classification of Diseases which was published in the RCGP Journal in 1972.

He gained his Membership of the Royal College of General Practitioners in 1972 and was made a Fellow in 1980.

Between 1969 and 1972 he organized the building of Bristol's first Postgraduate Centre at Frenchay Hospital.

During his retirement he remained

active and enthusiastic. He was Secretary of the Sir Alexander Lawrence Woodland Trust, a member of the Avon Wildlife Trust, and was involved in both local and national politics, narrowly missing a seat on the Council during the recent election.

On 29 May 1991 he died suddenly at his home in North Stoke, Bath. He leaves two sons (Nigel and Toby), three daughters, (Sally, Helen and Clare) and seven grandchildren.

All his friends and colleagues will remember well his boundless energy and kindness.

BGW

Sarah Stolz Lecture

The 1991 Sarah Stolz lecture was delivered by Professor William Parry-Jones on 'The Impact Of The Air Disaster On The Children Of Lockerbie'.

One night in December the small Scottish village of Lockerbie was suddenly, catastrophically and irrevocably changed. Most residents remember hearing a sound like thunder and have vivid memories of looking up to see a huge fireball. Debris rained down; bodies were scattered across the village and surrounding countryside (human remains continued to be discovered one year after the disaster); family and neighbours were killed; houses were destroyed (one year after the disaster many residents were still living in 'temporary' accommodation). Suddenly the town was the focus of attention for the world's media, and there were bitter complaints about the way the villagers were manipulated; then, equally suddenly, the press left and the residents were forgotten, but could not forget.

Professor Parry-Jones found that the community had become pre-occupied with the disaster, and that children were one of the main groups to suffer. The phenomenon of post-traumatic stress disorder (PTSD) has been extensively studied in adults and as a result of the work of Pye-Lewis and others, is being increasingly applied to children; PTSD includes recurrent nightmares, constriction of interests and psychic numbing, and preoccupation with the trauma in play, dreams, sounds and images, and non-specific symptoms such as fear, anxiety, startle reactions, etc.

In total, 121 cases were studied, this represents 13 per cent of the children and adolescents in Lockerbie. Both individual and family interviews were used to elicit information. Almost all of those investigated had significant symptoms of PTSD, and about 70 per cent showed loss of acquired skills, regression and new fears, especially of the dark or of being alone. One eight year old said, 'I can't stop think-

ing of it . . . it scares me in my head . . . it puts me off my work at school'.

One third of these cases were referred for treatment—almost none had received any prior support. However, uptake of treatment was poor, and this was partly attributed to changes in parental attitudes since the disaster.

Professor Parry-Jones concluded by emphasising the wide range of symptoms with which PTSD can present, and how these were influenced by the developmental stage of the patient. Although this may result in diagnostic and screening difficulties, PTSD was increasingly important from a psychiatric and medico-legal aspect, and he suggested that there was a necessity for child and adolescent mental health programmes following disasters. Professor Parry-Jones' own research was carried out one year after the disaster, at the behest of lawyers representing claimants.

This year's Sarah Stolz Lecture was thought-provoking, like so many of its predecessors, and I look forward with interest to next year's offering.

The Sarah Stolz lectures were endowed by Dr Henry Winsley-Stolz to commemorate his mother, who suffered racial and religious persecution in Nazi Germany, and to give recognition to the part the mother plays in the education of her children.

A Colour Atlas of The Brain & Spinal Cord MA England and J Wakely Wolfe Publishing Ltd, London. 1991 288 pages—£32.00

In the words of the authors, this text is designed as 'an introduction to neuroanatomy for medical, nursing and paramedical students and as a review for those familiar with this subject'.

Neuroanatomy is often considered to be a particularly difficult subject and much of this illusion stems from an inadequate grasp of the relevant terminology. Unlike most texts on this subject, this colour atlas contains a glossary with clear definitions of many terms which are vital to a full understanding of the subject.

The atlas is separated into two major sections. The first deals with structural features of the central nervous system whilst the second concentrates on the functional aspect of features of the CNS. Although an atlas, rather than a neuroanatomy text, this book serves extremely well to illustrate most aspects of this very complicated subject, and conveys the importance of the relationship between structure and function.

The authors have gone to considerable lengths to produce illustrations and sections which beautifully illustrate the topic and many of these have been prepared specifically for this text.

This is a first class atlas which should be consulted by all students studying the human central nervous system. At £32.00 it may be outwith many pockets, but copies should most certainly be purchased by the libraries and be made available to all students.

Dr S M MacLaughlin
Division of Anatomy and Cell Biology

Surgical Diagnosis and Management. DC Dunn and N Rawlinson, Blackwell Scientific Publications, 2nd edition, soft cover. Price £17.95.

This is the second edition of a textbook that was designed to meet the demands of the Cambridge medical students and housemen by providing a concise practical text. The first chapter deals with daily management of surgical patients on the ward, the second deals with prescribing, and the remaining ten chapters deal with the conventional surgical topics.

The first two chapters are more directed to the houseman and are well set out and contain much useful information. I disagree with the comment (page 34) that the daily postoperative round is the duty of the houseman as this round should be done by the Senior House Officer or Registrar. However there were many useful tips that will help the houseman to organise his thinking and routine.

On more detailed reading there were one or two criticisms of content on the basis of incorrect or missing information. With regards to risk factors for postoperative deep vein thrombosis, smoking does not increase the risk and may reduce it. The fibrinogen test for detection of developing deep vein thrombosis uses ^{125}Ia fibrinogen and not ^{131}IAc fibrinogen. The authors I felt rather dismissed venography for diagnosis of deep vein thrombosis, which is still the gold standard to which other tests are compared. They also state that venography induces deep vein thrombosis which is really a hangover from the early days, but with the non-ionic contrast media in use nowadays followed by heparin flush this was not a significant problem in a personal series of over 400 venograms. This book has been updated but unfortunately does not mention subcutaneous use of heparin in the treatment of deep vein thrombosis nor does it mention low molecular weight heparin.

My only other criticism is the use of operation codes which estimate the blood requirements, type of anaesthesia, the operation time, hospital stay, drainage time, suture time and time off work for individual operations. All these factors vary so much that I do not think it is worth categorising each operation on this basis. Indeed the majority of younger surgeons do not use abdominal drains anyway. These variables are something that can be learnt on the business rounds.

However my general impression is that this textbook would be advantageous to the student and houseman. It is well laid out with clear format and illustrations and is very reasonably priced.

A R Hedges

Tutorials For Junior Students Of Surgery. G L Hill and A G Hill, Churchill Livingstone, First edition, pp. 124, soft cover. Price £6.95

This book has been designed to provide a core of information that needs to be known by medical students by the end of their first clinical year. The authors are from New Zealand and this book must have been designed with their training as the basis. I think the book suffers as a consequence, many references are made to the incidence

of diseases as they occur in New Zealand.

Similarly clinical practise differs in the two countries. For example, the authors clearly have little experience of the thoughts of British Radiologists when during the topic of intestinal obstruction they recommend a routine erect abdominal X-ray to look for fluid levels. I cannot exactly remember when I last requested a routine erect abdominal film, but it was several years ago. Similarly in this chapter (page 30) I am intrigued to know how a patient with large bowel obstruction presents with 'hypogastric green apple colic and obstipation'—is this a New Zealand term for something that happens if you eat unripe apples?

There are several important facts missing on some topics and details included that are unnecessary. For example in the tutorial on gallstones there is no mention of gall stone ileus as a complication. However we learn that Dr Jean Charcot (of the triad) gave lectures on neuropathic joints and Dr John Murphy (of the sign) was trained in Vienna by Billroth (of the gastrectomy). Interesting facts but clearly not required of the medical student.

Terminology is also different. The authors talk of injecting 'dye' down the T-tube not using the proper term 'contrast'. There is also no mention of laparoscopic removal of the gall bladder. In the vascular section the authors suggest that ruptured aortic aneurysms present with expansile pulsatile masses. It is precisely the fact that having ruptured the ensuing hypotension makes the aneurysm difficult to feel that the diagnosis is often difficult to make.

However enough of the criticisms I was enlightened to read that they acknowledged the fact that Tamoxifen works in oestrogen receptor negative tumours and that its action may be by inhibition of growth factors involved in carcinogenesis. As a student I could never understand why tamoxifen was the treatment of choice in postmenopausal women with advanced breast cancer.

I do not think that this book can be recommended and I would hope that the topics would be covered adequately in the first year clinical teaching.

A R Hedges

DENTAL NOTES

Oral Surgery

The Dental Society lecture programme continued with an entertaining lecture by Mr Derek Henderson, Consultant Oral and Maxillofacial Surgeon at St Thomas' Hospital. The lecture was entitled 'The Maxilla as a Surgical Substrate'.

A King's graduate, Mr Henderson worked at Cannisburn Hospital, near

Glasgow. It was there he gained experience in the treatment of trauma to the facial skeleton, before moving to St Thomas'. He began the lecture showing a dramatic slide of an excised maxilla and confidently told an enthralled audience: 'Anyone with a small amount of surgical experience can chop out a maxilla.'

However, the emphasis of the lecture was not on excision but on maintenance of a healthy maxilla after trauma or surgical repositioning to improve appearance and function. This is slightly more difficult—it is necessary to consider the blood supply, attachments and subsequent fixation of the maxilla once mobilised.

Surgery has progressed with constant developments and improvement in the treatment of trauma patients. Through their injuries, more has been learnt about the blood supply of the maxilla and the best methods of mobilisation have been developed, ensuring a good prognosis for the mobilised fragments.

Fixation has also improved—in the early 1960's it was achieved with a plaster head cap and rods. However the head cap quickly loosened, and in the late 1960's the 'Halo frame' was developed, utilising intra-osseous pins. Now pins and rods are used solely in the region of the face, and these are often combined with internal fixation using plates and screws.

Mr Henderson showed many slides to illustrate the dramatic improvements in appearance now possible using maxillary osteotomies. He also encouraged the audience to think of the whole patient rather than the part—to think of the patient in space, time, pathology and with humanity. This statement surely applies to patients treated in General Dental Practice, as much as to patients undergoing surgery.

Professor Rowe, when introducing Mr Henderson, said, 'He is a wizard at Oral Surgery.' The Dental Society agrees and would like to thank Mr Henderson for a most enjoyable lecture.

Christina Beecroft

Alcoholism

The subject was one close to all our hearts, and promised to be an entertaining and frank insight into what is one of the most accepted social activities known to man.

Indeed 'Alcohol—the facts', might have been a more appropriate title as Dr Morgan, from the Royal Free Hospital, began to unravel the mystery behind the bottle. Her lecture began with the basic facts and figures about alcohol consumption. For example, one pint of beer contains on average 5% alcohol (16 g). This is rapidly absorbed into the blood and peak levels are found after one hour, giving the average man a blood alcohol level of 32 mg% and woman, 45 mg%. Bearing in mind the legal limit for driving is 80 mg%, the time taken for blood alcohol levels to reach zero varies between 8–12 hrs; Dr Morgan emphasised this point by narrating a tale about a doctor, who after drinking rather heavily at a New Year's Party, was stopped and the next day prosecuted for drink driving after innocently answering a call from the hospital—the moral of the story is quite simply *DON'T DRINK AND DRIVE.*

The British system for quantifying alcohol content in beverages—the Unit system—was put under the microscope and succumbed to the close scrutiny. A system based on a standard British pub measure is pointless argued Dr Morgan, since this measure does not exist in real life. A possible alternative would be to have specified on the can/bottle the alcohol content in mg%. However, in theory, 1 unit contains 8 g alcohol and is equivalent to half a pint of draught beer, one 4 oz glass of wine, one pub measure of spirits etc. A word of warning, though—don't be fooled by canned alcohol: each can may contain up to four units and bottles, possibly even six!! A sobering thought is the fact that at home, what may appear to be a single, modest measure of spirits poured with tender, loving care, is in reality, most probably at the very least, a treble pub measure.

As the lecture proceeded, Dr Morgan enlightened, the by now, totally entranced (and anxious) audience about the detrimental effects of consuming alcohol in excess of the minimum recommended weekly intake of 21 units for men, and 14 for women. Using her broad collection of well-chosen and clearly presented slides, she was able not only to categorise and describe a large variety of conditions affecting particular systems and organs of the body, but also to give clinical illustrations of a sample of them including liver and pancreatic manifestations. It was particularly interesting to note that alcoholism of the same extent in two separate individuals may present with alarming differences; one patient may appear to be totally asymptomatic whereas the other may suffer severe and often fatal consequences. The overall message to be gained from this summary, was that there is no safe level of alcohol consumption, but statistically it has been shown that if the recommended values are adhered to, the risk of physical damage is probably insignificant.

By this stage, certain members of the audience were becoming particularly restless and breaking out into cold sweats! The ladies present were not left out though, as Dr Morgan revealed a study she had carried out where a comparison was made between the drinking habits of medical and dental students, arts students and young people in the community. In it, she had found that male students across the spectrum tended to all drink comparable amounts, whereas female medical and dental students outdrank their counterparts appreciably. This tendency could also be related to clinical and examination performance—I leave it to you to work out how!

After lecturing for one hour, which seemed to pass very quickly, Dr Morgan was invited to answer questions from the floor, which she did with great authority and conviction. During the questions, it seemed as though a miracle cure for alcoholics had been revealed—100 g of Fructose with alcohol tends to cause faster metabolism of the 'offending' liquid and thus allows for greater consumption; well, at least in theory anyway! This news appeared to calm the nerves of the audience which was comprised of about 40 students, but a distinct lack of lecturers and demonstrators (draw from this what you will!)

Overall, Dr Morgan gave the Dental Society a most revealing and thought-provoking lecture. This was greatly appreciated and we sincerely hope she will return again.

A Banerjee

Whither The New School?

Readers of the *Gazette* will be familiar with the amalgamation of Guy's and St Thomas Medical Schools to form UMDS a few years ago. The Physiotherapy School, as my sister column has outlined, has gone elsewhere and now it is the nurses' turn for upheaval. From April 1 this year the Thomas Guy and Lewisham, the Olive Hayden and other satellite schools, have combined with the Nightingale School to form the Nightingale and Guy's College of Nursing and Midwifery. The sixteen schools of nursing in the South East Thames Region have been reduced to five colleges integrating trainng in nursing, midwifery and health visiting. Schumacher has definitely been consigned to the role of fish and chip wrapper.

At the helm of our vast new enterprise is the very pleasant and approachable new Director, Maureen Theobald. She comes to this task from the University of Sussex where she was Director of the East Sussex and West Kent College of Nursing, Midwifery and Health Visiting. But she is no stranger to the polluted city air: she trained at St Olave's and others will recall when she was a tutor in the School of Nursing here. Though spending quite a few of her hours at Guy's, her HQ is on the St Thomas' campus at Gassiot House. At the moment the curricula of the respective schools comprising the new body will continue until Project 2000 commences in 1993. So badges of each training establishment will continue to be awarded for those currently in training. When Project 2000 comes into being there will still be a distribution of teaching sites across the campuses until such time as the ideal of a single college building may be realized.

Ms Theobald stated I was wrong to suppose that students of Project 2000 meant 'bottoms on seats'—there will be adequate contact with patients. Nursing is still to remain a very practical affair, but clients of the future in an ageing population will more likely be in the community than the hospital. The emphasis in training will tend toward health promotion, as opposed to past training, which has been disease treatment oriented.

Supernumerary students of Project 2000 will generate the need for a higher profile to be granted to health care assistants.

Ms Theobald sees qualified nurses at the pivot, determining the correct skill-mix and manpower needs. The new college will have contracts for training both students and assistants with the Trust and Health Authorities for their respective locales. Ms Theobald hopes at least ten per cent of those assistants accredited via the National Vocational Qualifications at level IV will decide to enter nurse training. Thus someone entering at a low level, in Ms Theobald's words, with say a GCSE in woodwork may eventually, with Health Care Assistant accreditation and nurse training under Project 2000 finally achieve a Masters Degree in Nursing through such institutions as the South Bank Polytechnic. John Major beware imitators! Coincidentally South Bank is relinquishing its own independent degree course in nursing as at present conducted.

I asked Ms Theobald how she expected to find enough entrants to nurse training. Only three years ago demographic tendencies indicated a paucity of youngsters on the market as prospective student nurses. But no longer: the recession bites, and alongside improved retention of staff, the entry gate has been lifted to ensure no

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barrier is raised on grounds of sex, ethnic origin or age. Although the nation's economic fortune seems to change almost as frequently as the seasons, I forebore to ask Ms Theobald what she anticipated if and when boom time arrives or Europe intervenes adversely and employment patterns change.

Doctors will be interested to know that Ms Theobald dismisses the idea that nurses are their handmaidens, also, some who call for the return of Matron are casting backward glances through rose tinted spectacles. Nevertheless their cry does indicate a gap in accountability.

The League of Nurses may be sorry to see their own Thomas Guy and Lewisham School disappear. If amalgamations elsewhere are a guide, the distribution of training across various sites will lead to a loss of identity and hence a difficulty in recruiting future members to the brigade of old girls—with a few boys! But I think they should recognize in Ms Theobald a stout supporter in the continuing tradition of professional nursing and its development as it proceeds towards the twenty-first century.

Denis Cobell

The Physio Ball

A wonderful smell of crispy bacon pervaded Shepherd's House on Thursday 6 June. At first it was thought that the OT's were cooking breakfast with their patients—but a trail of physiotherapists, looking like Bisto-Kids, was met at the OT Kitchen door with disappointment. At last it was realised that there was a Barbeque on the front lawn which was supporting the Friends' Fête. Many of the physiotherapists had a tasty lunch on that auspicious day.

But how did the second year students survive the onslaught on their senses, of smells and sounds, while they were struggling with their end of year exams? The Friends had kindly agreed to keep the music down until mid-day when the exams finished. We are all grateful to them for their co-operation. After the exams finished and before going off on a spree, the students repaired to their common room to elect the student representatives and officers of the Students' Union for next year. Next year, the last year of the Guy's School of Physiotherapy, there will be only 30 students left. They have shown great solidarity and interest and many nominations were proposed. Voting took place briskly to elect President, Treasurer, Secretary, Social Secretary etc. And so, although there will be few Physiotherapy students, there will be business as usual.

Some *Prima Donnas* are prone to

repeated 'final' performances, due to egocentricity or financial considerations. The Guy's Hospital School of Physiotherapy Charity Ball seemed in danger of doing the same, but not for the same reasons. The 'final' Charity Ball held last year was so successful that it has been repeated as the '*Very* final' Ball this year. That is was once again a success is unsurprising but reflects even greater credit on the now smaller student body involved. The charity chosen—Action Research for Crippled Children—emphasises the young and the future, thus being an appropriately optimistic—almost defiant—last gesture from our shrinking school. An exact figure is not yet available but a sum of about £2,000 was raised for the chosen charity.

The Ball was held at the Scandic Crown Hotel in Rotherhithe and guests could have their pre-prandial drinks on the deck of the *Dame de Serk*—a three master in dry dock beside the hotel. Brigantine? Ketch? Barque? Lugger? Schooner? A wealth of opinion but a dearth of naval knowledge. The food and drinks were excellent, the speeches short, the music loud, all combining to ensure a thoroughly enjoyable evening and worthy to be the best and last of its kind.

St Thomas' School of Physiotherapy celebrated 80 years of Physiotherapy Education and some of us were invited to the party on 13 June. It is therefore 3 years older than the Guy's School which celebrated 75 years of age in 1989. These two venerable schools will hand over the training of Physiotherapy students with dignity to the following establishments at the end of the next academic year. Prepare yourselves for this sad occasion. It will be advertised so that the closure will be marked positively by those who have been involved with these two great learning institutions.

John Low
Diana Innocenti

GAZETTE SPORT

Boat Club

UH Bumps Report 13–15 May 1991.
This years UH Bumps was organised by St Bartholomew's Hospital. As usual there were only 3 divisions of about 25 boats each, which meant Guy's were unable to enter as many crews as they would have liked. Despite this crews from the Hockey, Rugby, and Ski clubs took part, as well as an Oxbridge crew. Eleven crews were entered in total.

Mens 1st VIII
After a period of intensive preparation and several pre-Bumps races with other Hospi-

tal crews, the VIII approached the first night with confidence. Starting off at 4, the crew had an excellent start and came within ¼ length of the St Thomas' 1st VIII. Despite a hard chase, and excellent steering we were unable to overlap the boats. St Thomas's were more prepared on the second and third nights, and despite good starts half-to-one length of water separated both boats at the UL Boat House. So Guy's 1st VIII remained at position 4. The only crew to 'bump' in the top seven positions were St Mary's; this indicates how closely matched all the hospital first boats are at the moment.

Mens 2nd VIII

The 2nd VIII had a good start on the first night, but despite this the London crew gained steadily. They were held off until Kew Road Bridge, when unfortunately we were bumped down from 18 to 19. On the next night the VIII were forced to row over as the 4 crews in front bumped early in the race. On the final night, the crew had an excellent start and gained steadily on the UCH crew in front, but never quite managed to put enough power into a 'Bumping 10' and thus remained at 19.

Freshman VIII

This crew, made up entirely of rowers who started at the beginning of the season started their first race in the best possible way—overbump from 16 to 13. On the second night they were denied a second overbump by the Bart's crew who managed to attach the bow of their VIII to the stake, and so turned around in the stream. On the third night the crew rowed over to finish in twelfth place in the second division.

I would like to thank all those people who came to support the crews and those who braved the river to act as 'pushers off'.

John Crossman, Captain

Tideway Head of the River

The curse—the formidable Oxford and Cambridge boat race in reverse, was the most physically demanding of the reads this year and rough conditions and a strong headwind made matters worse. Despite this the crew got off to an aggressive start, driving hard over the first mile. It was unfortunate that we were placed behind a faster eight competing at a higher level thus forcing us to race 'blindfold'. Admirably this did not interfere with our concentration and the the crew settled to a sharp, steady rhythm snapping the boat through the swirling water. The team worked hard to the call 'sit up, sit up and drive!'

The most striking point of the race was in the final mile when Phetna Fozouni, our cox, called for successive bursts of effort, 'Push in 3, in 2, in 1, go!'. Immediately the crew responded by slamming their legs down for three strokes and spinning the rate up. With each stroke the boat lifted and surged towards Putney Bridge. The final drive for home was made in front of the crowds to the public announcement 'Guy's first eight, the first London Hospital eight to finish . . . '.

This was an appropriate end to the season for the successful Guy's and St Thomas' corporate crew, which share from its ruthless coaching and strong spirit.

Crew: Bow John Crossman, 2 John Robin, 3 Andy Armitage, 4 Steve Poyke, 5 Matt Smith, 6 Justin Rodgers, 7 Matt Gray, Stoke Rob Weir, Cox Phetna Fozouni

Rob Weir

The Bumps—Ladies Report

The same manic, egg-throwing, chaotic atmosphere surrounded this year's Bumps. With St Thomas not being able to produce a first crew at number 4, our Ladies 1st VIII was out to win. The unfortunate St Thomas' crew did not even make it off the bank the first day so the Royal Free took them within 10 strokes, leaving us, at number 6, to row-over (not recommended to anyone). The following two days saw us bump up to number 4, beating the defeated St Thomas' crew and the Royal Free after a 40 stroke battle and several false starts.

The 2nd VIII did admirably well, despite Bow making the seemingly impossible mistake of geting lost on the train between Waterloo and Kew Bridge; Linda, who had never even seen a blade before, let alone rowed with one, was thrown in the boat at the last minute and did very well, considering!

The Crab-Catchers (alias the Ladies Hockey Club) took up their usual place, first out of the bushes, but sadly made it no further. However, they made up for it with their Grease costumes complete with shades, ghetto-blaster and 'bow-ball'.

As for the 'Dental Crew', I think they wondered why they were rowing, after rowing-over twice on the first day, first at the bottom of the Ladies race and secondly at the top of the Ladies division. On the second day they cheered up because they bumped up; they smiled even more on Wednesday, after a small agreement with the Hockey Crew, allowing them to bump each other and so avoid the notorious row-over.

Well done to all the crews and coxes—experienced or otherwise. See you in the City Barge next year.

Diana Bessey, Ladies Captain

Ladies Boat Club

The Ladies IV has had some memorable regattas since April—both for good and bad reasons. We started the season with a pleasing first heat at Hammersmith, rowing through Mortlake, Anglia and Alpha, and Thames at the end of the race.

In the final, we were beaten off the start but caught up with the winning crew, and were only ¼ length down at the finish.

The following week we arrived at Marlow, full of optimism and cheered on by supporters, but unfortunately we could not increase the rating sufficient to match the other crews and lost by 2 lengths.

However, our spirits were high and we proved that we could win at Borne Women's Regatta. The first round was the hardest, being drawn against Mortlake, Anglia and Alpha 'A' and Thames 'A'. The race had to be restarted due to the crazy cox of MAA crashing into Thames after the first ten strokes! We steered well clear of them in the re-race, with MAA going ahead at the start and Thames and us each ¾ length down. In the last half minute MAA lost all their momentum, we saw our chance and burned like never before! We just beat Thames by a canvas. The final was not nearly as exciting or nerve-racking, with our IV leading by 2 lengths all the way, over Sons of the Thames. Champagne never tasted so good as it did from our first Senior 3 tankards.

After the Bumps, we went for the Metropolitan Regatta on the Royal Albert Docks—a fantastic 6-lane course, if the weather is calm. We had a poor row due to various crew injuries, coming fourth, but only half a length down on Oxford Polytechnic who eventually won the Bronze medal.

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On the 8–9 June, we were back there again, racing in the Docklands Regatta. On the Sunday we came third in the first round, after Bath University and Bedford High School. However, in the *repecharge* (all crew who came second or third in the first heats) we beat all five crews, to win by about 4 lengths. By this stage, we were gunning for at least the Bronze in the final, having discussed the capabilities of the other crews. We were all very disappointed when the afternoon's racing was cancelled due to very high winds turning the dock into a rough sea.

Our ultimate goal had been to win at Women's Henley on 22 June. However, this was not to be, despite intensive training on land and water, and practising on the course two days beforehand. We were prepared to qualify on the Friday night, but we did not even do that because two crews scratched. The next morning after forcing down a Weetabix at breakfast, we drove down to the river to meet our families and friends who had got up at the crack-of-dawn to make it on time. We saw the standard of some of the crews and were fairly optimistic. But, bad luck befell us again, being drawn against an invitation crew from Edinburgh University. We went off together at the start, against a strong head wind and choppy water. The Edinburgh crew was much heavier, which is an advantage in such conditions, and gradually went ahead to win by 5 lengths.

We were all bitterly disappointed to lose in the first round to a crew that got to the final. Despite this, we are planning our revenge at the Richmond and Kingston Regattas on 29 June and 13 July respectively.

Thank you to Alex Hodges, Chris Madell, Jamie Rose and Andy Williams for coaching, plus everyone else who has supported or helped us at some stage (including the 'Rowing Widower's Association')!

The crew: Bow: Sasha Mayes. 2: Liz Gibson. 3: Caroline Burt. Stroke: Diane Bessey. Cox: Andy Klein.

Diane Bessey

Squash Club

First IV Squash, 1990–91

This team had a very successful season to repair the damage caused by an organisational tragedy the previous season.

The team started off in division 3 along with several other of our teams. This lowly position was the result of slipups the previous season where for one reason or another matches were not played or results not handed in. In the first half of the season no player lost a single match and there were occasions when players did not lose a single point! Points were finally lost when the last game of the season was attended by only 2 players. Even then by each winning 3–0 we were able to draw the match. We finished top of the division gaining 37½ points out of a possible 40 and were promoted to division 2 for the second half of the season.

This division was a totally different kettle of fish and the team had to contend with absences due to illness, peripherals and electives all of which deprived us of our full strengths on many occasions. Despite this we managed to secure 37½ points out of a total of 45. With these results it is likely that we will be promoted to division 1 next year.

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Death

BLAIKLEY, Bruce John. Died peacefully on May 11, 1991, darling husband of Dawn (née Townsend) SRN, father of Andrew (Guy's 1979–84) and David. Son of the late John and Vivien.

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The Front View of Guy's Hospital, 1924. It is rather more difficult to park at Guy's in 1991.

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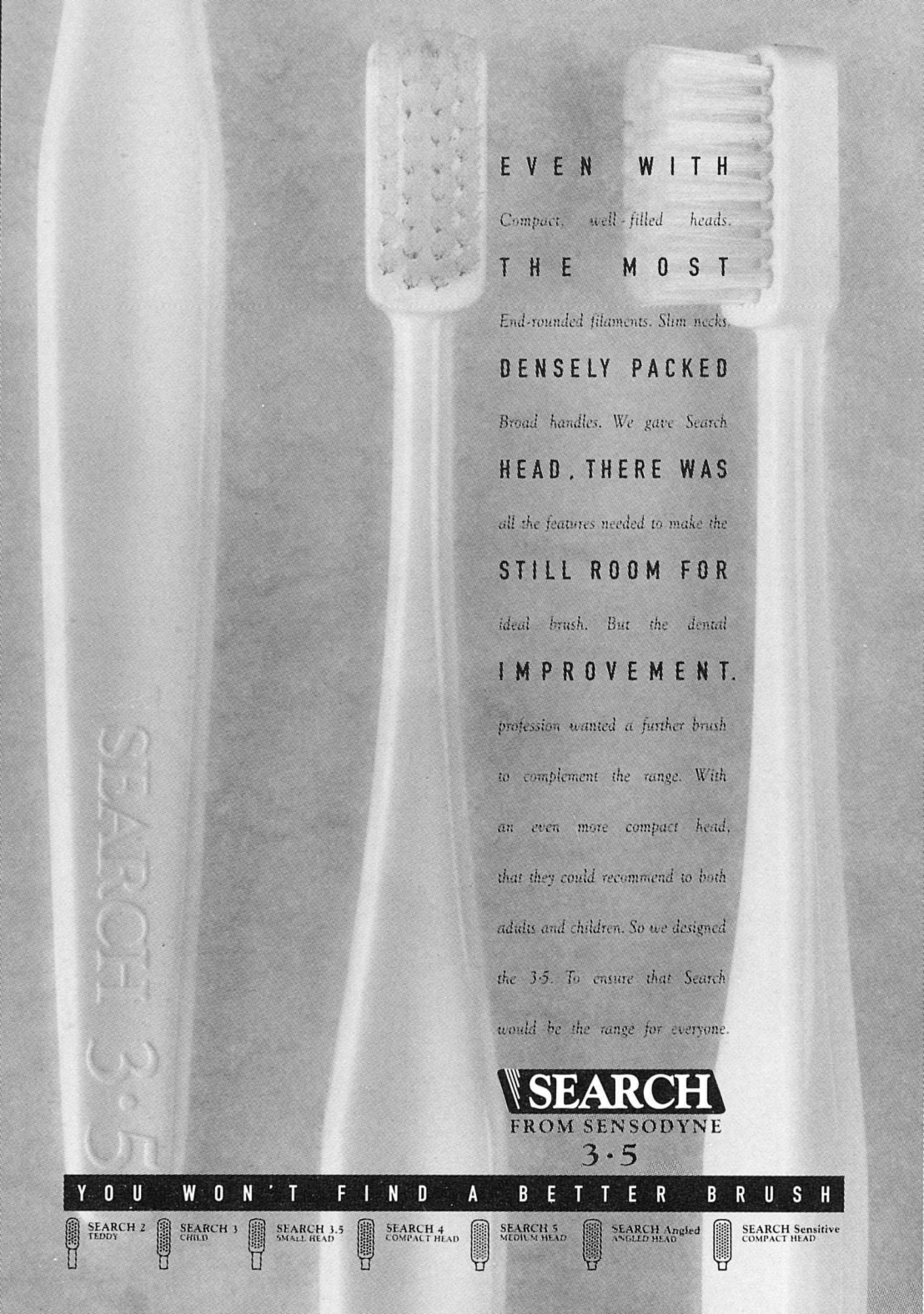
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Guy's Gazette

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Volume 105 Number 2415 September 1991
ISSN 0017-5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

This month Guy's Hospital plays host to the annual medical student conference. This event, which is sponsored by the MDU creates the opportunity for medical students from throughout the United Kingdom to meet and discuss educational and medical issues. At UMDS, of course, the pre-clinical and clinical courses have recently undergone a welcome review, and it will be interesting to learn how these curricula now compare with those of our contemporaries.

It will also be enlightening to hear about the state of the NHS outside of London, as medical students are a rather parochial bunch, and the media tends to concentrate almost entirely on London and south-east England.

The past year has been one of great change for the Hospital. April saw the introduction of Trust status; we have seen the beginnings of Sir Philip Harris House; and, most recently, the proposals for a merger with King's College Hospital. We recognize the logistical reasoning behind these proposals and the basic educational benefits that might accrue from such a merger, but hope that it will not result in a loss of affinity for the constituent hospitals. The future of the *Gazette*, for example, depends on students feeling a part of this hospital and the wider benefits and pleasures of education might be lost. We are confident that these considerations are being taken into account.

This month is my last as Editor of the *Gazette*, and also marks the departure of Alastair Santhouse as Deputy Editor. The Editor-designate is Fuad Hussain, a first year clinical student, whom I should like to wish every success in continuing with the *Gazette*. I have very much enjoyed my time as Editor, and I hope that Fuad will find the role equally rewarding. Over the past year, many people have helped make the job memorable and enjoyable. In particular, I would like to thank Dr R K Knight of the *Gazette* Committee, all the regular contributors and the *Gazette* staff—especially Dr Kausér Pervin, who found time to help despite her exacting research commitments, and also my thanks go to the Office Manager, Mrs Margaret Flanders.

The Dental Society Presidents

Dear Sir,

What a splendid body of men your photograph of the Past Presidents of the Dental Society in the last issue of the *Gazette* (now happily restored to all its A5 glory) shows.

Even better in *BDJ* colour.

The list of names on the Board, reading like Henry's roll call before Agincourt, evokes a host of memories for those of us who came to Guy's immediately after the war.

After five years of service life, being bullied (no pun intended) by our own side and discomforted by the other, to be received into Guy's and be permitted to receive our instruction by these 'gentleman dental surgeons', must be what one experiences on passing through the Pearly Gates. For us it was the greatest privilege to know and be taught by these men.

One could single out Freddie Doubleday (disliking his own local), Ronnie Rix of the expressive hands, Messenger's Megatherium molars; Prof Fenn (did he really keep goats?) and Cyril Hagger, a quiet genius of surgery. Those two *parfait* (not another pun) knights, Martin Rushton and Kenneth Hooper from whom no lower eight remained as he wielded his winters like a wizard's wand.

And how good to see still with us, looking quite indestructable, Alan Thompson, Jimmy Mansie and Mick Vale.

Bliss was it in that dawn to be alive
But to be young was very heaven

Fonteyn and Flagstadt at Covent Garden, Olivier and Redgrave at the Old Vic, Compton and Edrich at Lords . . .

Forty years ago? It seems only yesterday. That their faces, whose names are written large on the Roll of Honour Board remain so clear in our memory must be a measure of their stature and a tribute to what we owe them.

Yours faithfully,

TONY WATKINS
Prideaux
16 Prideaux Rd
Eastbourne
Surrey

Medical Student Conference

Dear Sir,

I am writing to tell you about the forthcoming conference to be held at Guy's Hospital. It is the annual MSSIS conference, which is attended by representatives from medical schools throughout Great Britain, and will take place over the weekend, September 20 to 22. This is the first time that this conference has been hosted here, indeed the first time it has been held in London in the last six years. The previous two conferences have been at Glasgow and Belfast Medical Schools. MSSIS in sponsored by the MDU, and aims to provide a central point through which medical student societies can keep in touch with each other, and from which they can obtain information of interest to them, and the conference itself is usually very informative, as well as an enjoyable social event.

The subject for the conference will be 'The NHS in the Nineties and Medical Education', and some of the speakers will

come from within the Guy's Trust and from UMDS staff. Among the venues around the hospital in use will be the Robens Suite, the Keats' Restaurant, the Harris lecture theatre and Gordon Museum in the Medical School, and of course the Students' Bar for a rousing finale.

The delegates from UMDS will consist of the two student Campus Committees, and all delegates will be staying in Wolfson House over that weekend. If anyone is interested in attending the talks, or would like more information about MSSIS, please contact me via the pigeon holes in Boland House at Guy's.

Yours faithfully,

ANDREW KLEIN
(Medical Student)
MSSIS Rep and Conference Organiser
Boland House

Rainy Days

Dear Sir,

On holiday in Sweden recently we experienced a couple of rainy days. Fortunately I was behind on my *Gazette* reading and had packed the last 3 months issues. How useful is the A5 size for pocket and briefcase. Please keep this style and size.

Yours faithfully,

Dr C J HUGHES
18B Copse Mead
Woodley
Berks RG5 4RP

The MRCGP Exam

Dear Sir

I enjoyed Dr I M Stone's article in the May *Gazette* 'On being a GP in the 1990s', which I thought was a fair summary of the current situation. I was however bemused by the description of the MRCGP examination as 'somewhat maverick' (Chambers' definition being a *stray animal without an owner's brand, esp a calf: a dissentient: anything dishonestly obtained,—vt to seize without legal claim. [from Samuel Maverick, a Texas cattle-raiser]*).

Some 1,700–2,000 candidates take the two sittings of the MRCGP each year, 80% being GP trainees who must be within eight weeks of completing their three-year traineeship by the date of the orals. The examination is designed to test the knowledge, skills and attitudes of current and aspiring GPs, being set at a level appropriate to the end of vocational training. It consists of three papers and two half-hour orals; one paper, the Modified Essay Question, is a College invention but has been adopted widely by other family medicine examinations throughout the world.

The MRCGP examination has been widely researched and publishes its own statistical performance regularly—unique I believe for postgraduate medical examinations in this country. A full description has been published recently as an Occasional Paper obtainable from the Royal College of General Practitioners.

Yours faithfully,

PHILIP TOMBLESON MBE FRCGP
Convener, Panel of Examiners
RCGP
14 Prince's Gate
London

Prof T B Johnson

Dear Sir,

I have much enjoyed the articles by E D Y Grasby. I was at Guys 20 years after him—I regard myself as geriatric—so he must be venerable!

My reason for writing is to remark on great T B Johnson, Dean 1920–37, Professor of Anatomy, and a brilliant teacher under whom I had the honour to learn my anatomy, and also some humour. A charming man—unfortunately undergraduates don't realise how much has rubbed off the great men—or thought to thank them.

As his anatomical and surgical leadership is so well known, I shall not attempt to comment. Your younger readers may appreciate some non-surgical advice he gave us 43 years ago:

He who knows, and knows that he knows is a wise man—follow him.

He who knows, and knows not that he knows is asleep—wake him.

He who knows not and knows that he knows not is a child—teach him.

But he who knows not and feigns that he knows is a rogue—beat him!

TBJ (for the benefit of those who did not know him) had a Churchillian voice. I am sure many will have the recording of Churchill saying 'the whole British people were Lion-hearted—I just had the luck to give the *roar*'. Some understatement!

T B J used to say 'rogue' in the same way.

To me it is still Guy's—not UMDS—and how lucky I was to spend 5 years there.

Yours faithfully,

M J FAWCETT
2 Mill Yard
Natland Mill
Beck Lane
Kendal
Cumbria

Mr 'Joey' Hughes

Dear Sir,

I have read your *Guy's Gazette* feature 'Life at Pembury' by Mr E D Y Grasby and I was particularly interested to read his comments about Joey Hughes.

I first met Joey Hughes when I came to Pembury, as a clinical student, to do my midwifery in the summer of 1947. At this time Mr Hughes had retired from Guy's but maintained a surgical interest in Pembury Hospital and he gave us midwifery students an informal teaching session in surgery twice a week. He was a compassionate, caring man and was also a splendid teacher. I learned more surgery at Pembury in three weeks than I did in three months at Guy's.

In 1950 I returned to Pembury Hospital to do my House Officer Appointments and I was House Physician to Dr Miller when Joey Hughes was admitted to the Medical Ward in his last illness. This was a very sad time for all of us.

I shall always remember Joey Hughes with gratitude and affection. It was a great privilege to have known him.

Yours faithfully,

Dr G CANTY
21 Bannerdale Rd
Sheffield
S7 2DJ

Guy's Hospital Blues Committee

There will be a meeting of the Blues Committee at the end of September.

Nominations for Blues and Half Blues should be sent to Mr M J Gleeson, Secretary of the Blues Committee, Department of Surgery, Guy's Hospital by September 18. Nominations should be accompanied by a brief summary of the candidate's qualifications for the award.

New Chief Nurse

The Guy's and Lewisham Trust has appointed a new chief nurse. The job has gone to Wilma MacPherson, and she will also have a seat on the trust board. She is currently chief area nursing officer for Grampian Health Board.

Trust Review In October

The House of Commons health committee is to mount a 'major review' of NHS Trusts. The committee said in a report that evidence from Guy's and the Bradford trusts had prompted 'concern on a number of issues'.

The committee also warned against an emerging two-tier system in which some patients get faster treatment than others and against over-reliance on cost improvement programmes to boost funds.

Dr L S Rayfield

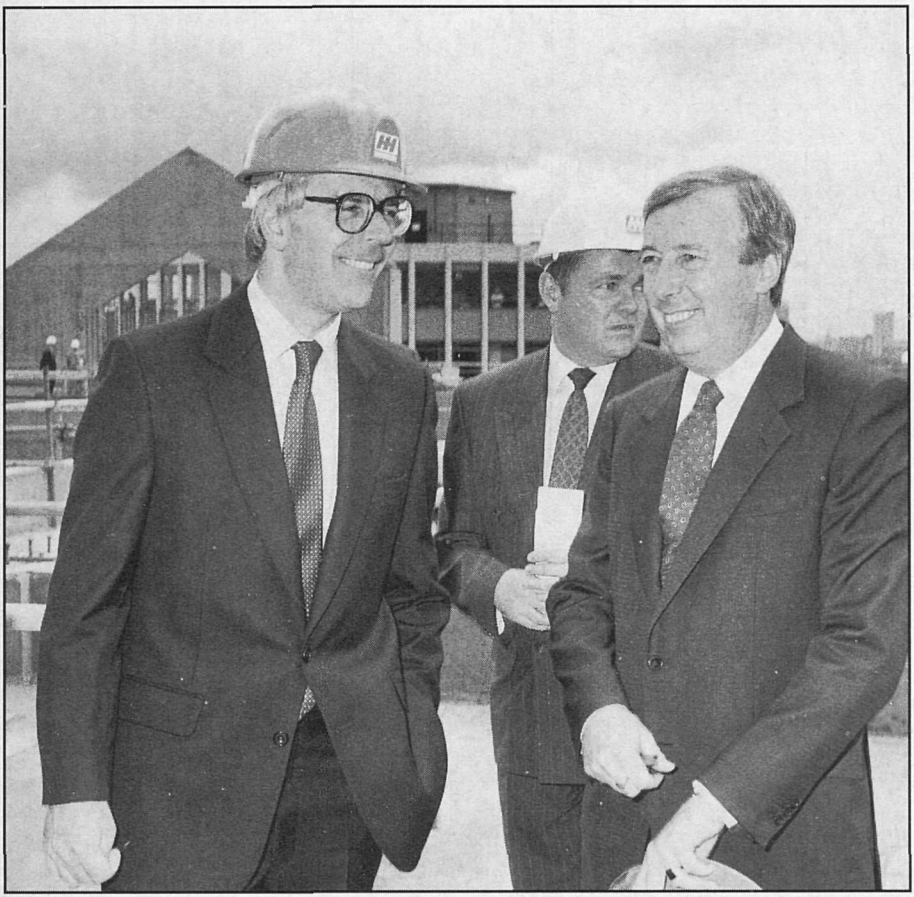
This month sees the departure of Dr Lee Rayfield from the department of immunology at Guy's. Dr Rayfield was a very popular lecturer, and was well-known by students for his lucid style of presentation. He was able to make complicated matters readily understandable and his obvious enthusiasm for immunology was often inspiring.

We wish him all the best in his future pursuits.

Mind Your Backs!

Loughborough University Training Group is currently offering a short course on Lifting and Handling in Hospitals, specifically for staff in the Health Care Services:
Manual Handling in the Health Care Services—21 November 1991
Full details are available from:—

Joyce Motyka
University Training Group,
University of Technology,
LOUGHBOROUGH,
Leics.



Above is a photograph of Mr John Major and Sir Philip Harris, Chairman of the Guy's and Lewisham Trust, at the topping out ceremony for Sir Philip Harris House. This represents the third phase of the rebuilding programme of Guy's. Photo: Trevor Stannard

When Syringes Were Made Of Glass

Life as a junior ward clerk

I stared at a notice in that corridor in the Medical School where they used to put these announcements. My name appeared to have been allocated to Professor Butterfield and Dr MacLean. Other names on that list were Dick Trompeter, Jeff Rosenberg, Graham Hey, Dave Elliott, Graham Voss, and John Soul. The saving grace of being a Junior Ward Clerk was that there were always the Senior Ward Clerks who could be relied upon to help us out; usually in the matter of blood-letting. Glass syringes were still the thing in those times and many a counterpane was splashed liberally with the ten cc's of blood that tended to fall downwards should the glass plunger fall from the end of the syringe—which it often did. There were Ward Sisters to contend with when this happened. On the whole, they were a very decent bunch to us junior students.

Of course, there were times when it was impossible to find a vein. At such moments it seemed like a miracle when chaps like Charles Thorburn or Tony Harrison could extract blood from the seemingly bloodless. I often wondered at the investigations asked for and for many months I wandered through the study of medicine not really knowing what I was doing. It is a phenomenon that still takes place, I trust.

Professor Butterfield was already a very big cheese. We all knew he was doing something but it was never made quite clear to me as to what it was. Nevertheless, it was a privilege to have been taught by him and bask in a tiny bit of the reflected glory. It's also quite nice these days when chatting with my patients to say—should the name of Butterfield ever crop up—that I was taught by him when he was *just* a Professor.

K S MacLean was a bluff, kindly man with a somewhat stern exterior which could melt for the patient and harden up for the mentally incompetent ward clerk. He had a wonderful way of saying 'You stupid boy!' to a chap which echoed quite wonderfully round wherever he happened to be in the ward. After that, the patients would be straining to hear every word that was said.

In the absence of Prof Butterfield, we were often taken for tutorials by Dr T J H Clark. He seemed a very keen type and was already regarded as jolly

bright. Once—I had to present a case of pulmonary aspergillosis in a 37 year old lady with multiple pulmonary cysts. She arrived on the ward with a file of notes an inch thick and a bundle of x-rays to match. If I'd been a barrister presenting the case in a court of law the following day, I'd have lost hands down—and so it was here. I opted for the safest line of presentation. The x-rays were in a shocking muddle and so I numbered them from one to seventeen in the order of their taking. I used that zinc oxide tape which was so terribly handy at the time. I memorised the patient's name and age and as much background as I could put forth. I wore my Prince of Wales three-piece tweed with the yellow paisley bow tie. Aquascutum's best—as I live and breath!

My presentation went smoothly until it came to matters involving clinical interpretation. At this juncture, I lapsed somewhat and began a detailed explanation of how I'd licked all her notes and x-rays into some kind of shape and I had probably launched myself into the advantages of zinc oxide tape as an adhesive label when Tim Clark cut across me: 'Look Pitt-Payne—this isn't a Country Club, you know—you haven't come here to enjoy yourself!'

I tried to look suitably crestfallen and instead gave him one of my most winning smiles. There was some laughter as I remember. Eventually, I was to become one of his House Physicians. It's a funny old world.

Those were the days of heating up urine in test tubes; looking at smears of blood down a microscope; calling one's elders 'sir'—and being referred to in turn by one's surname. We knew our place— or maybe I knew mine. At about the same time, flogging and fagging in the Public School system were on the wane; we would change from glass to plastic disposable syringes; sticks would be dipped into urine samples—and eventually blood counts would be done by computers. By the time I became a houseman we would be on the first name terms with the Students on our firms—but more of that another time.

J H Pitt-Payne

Mr Robin Carew Bret Day

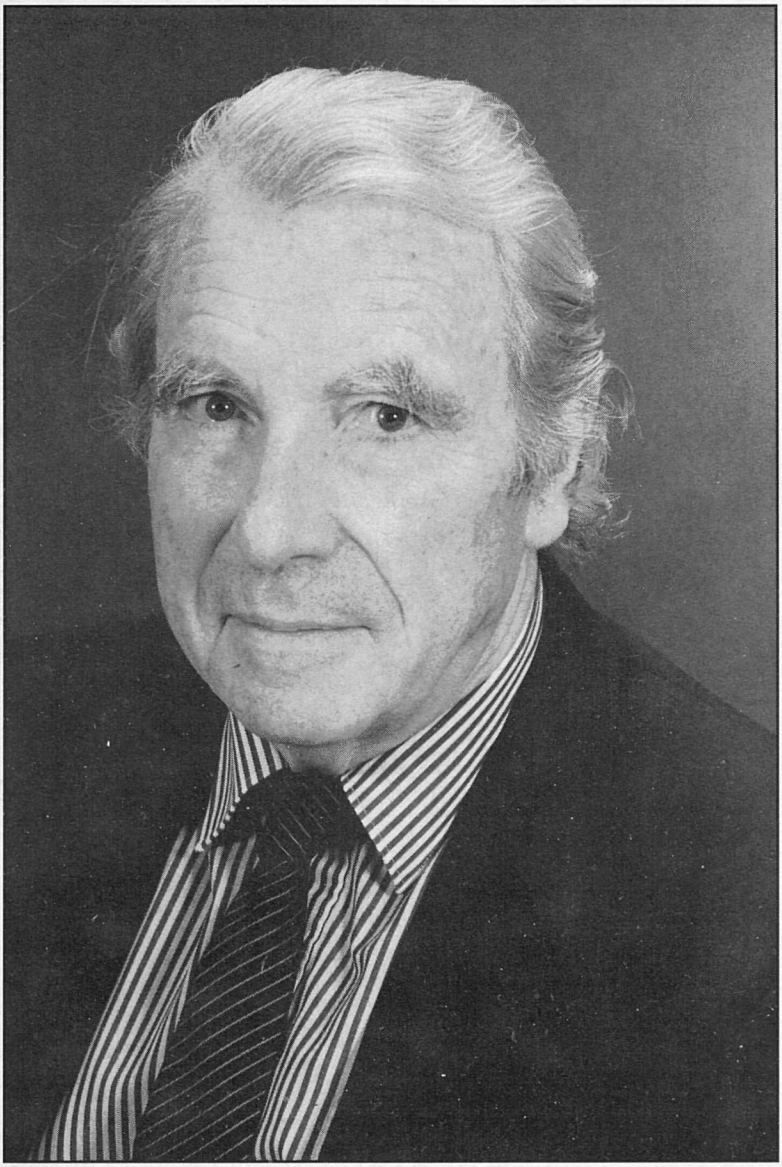
An appreciation

Mr Bret Day retired in August this year from his post as Senior Oral and Maxillo-Facial Surgeon and Head of the Department of Clinical Dental Surgery.

He came to Guy's in 1946 having spent his childhood and war years in occupied France, where he was actively involved with the French underground forces. At that time nearly all the student body were ex-servicemen and were considerably older than the Junior Dental Staff. Robin qualified LDS in 1951 and obtained the FDS RCS in 1954. At that time he showed a marked interest in Oral Surgery and in order to pursue that career he did the conjoint diploma and obtained the MRCS LRCP in 1958.

After hospital house jobs he was appointed in 1960 Locum Tenens Consultant Dental Surgeon to Queen Mary's Hospital, Sidcup and held this appointment on a part-time basis until 1964. In 1961 he was appointed a Senior Registrar to the Oral Surgery Department at Eastman Dental Hospital and Institute of Dental Surgery. After three years in this post he became Consultant Oral Surgeon to Edgware General Hospital where he served for two years. He was then appointed to the busier post of Consultant Oral Surgeon to Hillingdon Hospital, which is a designated accident centre and he worked there until 1978. As early as March 1966 he had Consultant sessions at Guy's Hospital and over the years he has gradually increased his commitment to Guy's. Throughout this period he has run a busy private practice in the West End where he specialises in Oral Surgery but also does a lot of Restorative Dentistry.

His ability as Chairman of committees has been widely recognised by the School and the Hospital. He has the unusual distinction for a member of the Dental staff of being Chairman of the Academic Board of the United Medical and Dental Schools. He has also been involved in many committees in the National Health Service, being Chairman of the Area Dental Committee for Lambeth Southwark and Lewisham from 1974–80, Chairman of the Dental Division of Guy's Hospital from 1972–85, and Chairman of the Dental Hospital Committee to



date. He was Vice-Chairman of the Medical and Dental Committee, which represents all the Consultants from 1974–86 and was Chairman of this important Committee from 1987–91. He faced the very difficult task of guiding the Medical and Dental Committee through the difficult discussions concerning the application for Trust status. His touches of humour often diffused tense moments.

On the national and international scene he has been much in demand as a lecturer and has visited many parts of the World, talking either on an aspect of Oral Surgery or, latterly, on his particular interest in Dental Sedation. His expertise in this direction led to his appointment as President of the European Federation for the Advancement of Anaesthesia in Dentistry and he served in this capacity from 1980–88 and he also served as a member of the Council of the Association of Dental Anaesthetists. He has made a number of important contributions to the literature of Oral Surgical topics.

Mr Bret Day has been a very popular member of staff with both his colleagues and students. His imposing figure and slight gallic accent have lent themselves to innumerable portrayals in the students' Christmas Review which have been greatly enjoyed by all, including himself.

Above all he is a most caring individual. Never too busy to see a patient, always ready to undertake whatever is necessary and the only way to make him really cross is if he thinks somebody has let down a patient. He will be sadly missed in the Dental School and Hospital and in the larger world of UMDS and the District. We wish him a long and happy retirement.

AHRR

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A Life Of Medicine

The final instalment of Mr E D Y Grasby's memoirs.

The Battle of Britain caused us much concern. We were right underneath it and bullets and shrapnel fell like rain, as did the occasional pilot. I always went to see any Germans and remember meeting one very young and terrified Luftwaffe pilot. He wore a magnificent uniform and was pale with fear. When I asked him in German his name he gave it at once along with sundry other information that I am quite sure he should never have divulged, but which I believe was useful to our Interrogation Officer. The contents of the boy's pockets were shown to me and included a pair of dividers with an india rubber to protect the points. I must have absent-mindedly put these into my white coat pocket. This young fellow turned out to be the son of a very high ranking Luftwaffe Commander, who was determined that his son should not be exposed to danger. He had a desk job but his father thought he should have some war experience and put him in a bomber flying a small, safe mission. Unfortunately, the bomber was diverted to a bombing raid on London, and down he came. No wonder the poor boy was scared stiff. I gave the dividers to my son—the rubber is on my present desk.

We also had pilots of the Polish Squadron, no 393. The were charming but impossible. I recall one of them saying to me, when I saw him in the ward—'Six days we fight—five German planes! Pooh.' He was disgusted with his efforts. They were excellent pilots, with one burning ambition—to kill Germans.

One English pilot I remember suffered bullet wounds when his plane was badly hit. They brought his parachute to show him what had brought him safely down. It was riddled with bullet holes! It looked like fine lace and this brave fellow turned white when he saw it. How it brought him down is a mystery.

Curious things did occur. I was standing outside my office when a Dornier bomber passed just above the wards and crashed somewhere near the village. It was completely silent with no engine noise and I suppose may have been abandoned by the crew. It was an eerie experience watching at a huge swastika glide above one's head.

But the stories of the War have been well recorded and we at Pembury were in a pretty safe place and were able to resume many of our normal duties. The

Mr E D Y Grasby

wards were filled with normal admissions of sick people or patients for cold surgery and we were very busy. The Maternity Unit was as busy as in peace time. We did have war casualties as well of course and many unhappy people transferred from London. The first doodlebug to pass over was typically German; it made such a vulgar sound. These wretched things continued to fly over us, but some were brought down by fighter planes and careered all over the sky before crashing to earth. The V2 rockets, I thought, were the most fiendish and revolting weapon ever conceived and I remember seeing the young girls from the Lewisham bomb, which caused so many facial injuries from flying glass.

We did still have concerts and dances and, in the summer, a garden fête. We raised quite a lot of money for the Red Cross and the Star and Garter Home, and Miss Edith Hughes, Joey Hughes' cousin, suggested that we should have a Friends of the Hospital, as at Guy's. She was the distinguished Head Mistress of the Girls' Grammar School in Tunbridge Wells. My wife, Mrs Garrett, our Chaplain, the Rev Philip Stewart-Browning, and Mrs Surrell, got together and our own League of Friends was formed. Miss Patience Slesinger—daughter of Judge Slesinger and niece of the actor and the Admiral—became our first Chairman. Our present Chairman is the Marchioness of Abergavenny who, in spite of her many duties, has guided us with charm and skill for more years than it would be gallant to disclose. The Hospital has reason to thank the League for thousands of pounds spent in its benefit.

Our first Chaplain was the Rev Eric Wells—father of John Wells the actor and playwright—a splendid fellow and great character. He was kind and helpful and did our patients a lot of good when he talked to them about their injuries and worries. He preached amusing but valuable sermons, frequently full of humour. We used to attend the services with Nurses and some patients in the Hospital Chapel. Many patients had spinal or bone injuries which meant that they lay on their backs in plaster beds. We thought it would be easier for nursing if we used one of the green stretchers, removed the metal mesh and incorporated the plaster bed into it. In this way the patient could be easily moved on the trolley wheels and, with a front plaster he could be turned over with comparative ease. It occured to me that some of these patients could be taken in our ambulance to the Chapel and the metal stretchers placed over the pews. The idea was well received and I got Bateup and his men to do it, entirely voluntarily. To see these fellows covering the middle of the Chapel, singing their heads off in full and ample voice and hear them laugh at Eric Wells's cheerful sallies was a joy in itself.

The end of the War did come and saw the gradual departure of our guests from Guy's and a return to more routine activities. John Carter-Brain continued to supervise the newly established Radio-Therapy Department, with Tony Waite, returning from the War. Norman Jacoby became our Paediatrician, E J Cooke

remained as an Anaesthetist, and W W Gilford joined our own surgeon J J Bell. My colleague, Ivor Thomas returned to resume his appointment in the Obstetric and Gynaecology Department,—I was delighted to see him back from service with the RAF. Many new appointments were made later. John Mayer, Orthopoedic Surgeon, R M Mill, Physician, Malcolm Henderson, Pathologist, J Briffa, Anaesthetist and Ian Henderson, Surgeon. Many more were to follow. The introduction of the National Health Service in 1948, settled the fate of all of us, and many were anxious about the seniority they would be granted. I resigned from my position of Surgeon Superintendent and reverted to being a simple Obstetrician and Gynaecologist and ultimately started in private practice. My duties were now undertaken by a Medical Committee of which I was the first Chairman. One observation I found fully confirmed during that time was: a Committee takes minutes and wastes hours.

I had examined for the CMB, but I was totally unprepared for a letter I received from the University of London, inviting me to join the panel of examiners for the London MB. I accepted and continued to examine for many years, even becoming one of the four senior examiners who set the papers and whose names were boldly printed at the top. I wondered if the examinees looked at the names and thought what awful questions the stinkers had set this time. There were many hilarious moments but one must suffice—one student appeared before us for his *Viva* and began by saying: 'Sir, I have an impediment in my speech from time to time, when I can't say a word but only spell it.' My colleague looked up from his *Times* and, no doubt, wondered as I did, what a curious mental aberration this was. However, I went on to ask him a simple question—the first always was—and said, 'I am sorry but I am sure we shall be able to manage. Now. Tell me what essential items would you want in a diet in pregnancy?'

He looked at me and then said, 'Proteins, carbohydrates and . . . ' whereupon he stood up, leaned towards me, pointed his finger and spelled out 'FATS'. My colleague was almost cowering under the table. I felt a bit under attack myself. And so it went on, but he wasn't very bright and we could not have passed him anyway. But I would have given an extra mark to the candidate who, asked how he would define Anatomy replied, 'Well Sir, it's something everybody has but it looks much better on a girl.'

I was also very honoured to be invited to examine for the Royal College of Obstetricians and Gynaecologists.

I decided to retire in 1968. I thought forty two years since qualification enough, and I wanted to be relieved of the stress and natural anxiety of a practising surgeon. I had bought a holiday home in Malta and my wife and I, who know the island well, thought we would luxuriate in the sunshine and certainly spend the winters there to avoid the cold of England.

It would be time to enjoy the memories of many friendships I had made at Guy's. Scott-Russel Trick, Charles Marshall, my best man at our wedding sixty years ago, the pleasures of the Biennial Dinner and 'Our Club', our many friendships here in Kent, and the sudden flashes of recollections long forgotten. As, for instance, my memory of the day, Dr A H Douthwaite had lunch with us at Pembury, after which he made a hurried departure and promptly perforated a peptic ulcer somewhere near Horsham, I believe. My wife was very disturbed that her lunch was to blame.

It also gave me time to write these rambling notes of those happy times and the fun we had, one of the few compensations of increasing years. But I recall with feeling, the story of the two aged Frenchmen, sitting in the Champs Elysees, drinking their pernod and watching the little midinettes mincing along the path when one turned to the other and said, 'Oh to be seventy again!'

Eheu fugaces labuntur anni.

E D Y Grasby

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Guy's Hospital Gazette Memorabilia

The Guy's Hospital Gazette Office is on the first floor of Boland House. The office is open 1–4 pm every weekday afternoon and a list of the memorabilia available is shown below.

Guy's Shield	£19.00
Pewter Tankards (engraved with Guy's crest)	
(1 pint)	£19.00
(½ pint)	£15.00
Pewter Goblets (engraved with Guy's gold crest)	£16.00
Guy's Key Rings (blue with gold crest)	.60p
Guy's Credit Card Holder (blue with gold crest)	.60p
Guy's Notelets (Set of 5)	£1.00
Guy's Playing Cards (in blue leather case with gold crest)	£3.75
Guy's Prints (15" × 12")	
Main Entrance	£7.00
Hunt's House	£7.00
Medical School	£7.00
The Park	£7.00
Guy's Etchings	
Main Entrance	£1.00
The Park	£1.00
Hunt's House	£1.00
The Colonnade	£1.00
Medical School	£1.00
Hip Flasks (4 oz leather encased; silver crest)	£10.00
Hip Flasks (6 oz leather encased; silver crest)	£15.00
Paper Weights (glass with blue or white crest)	£2.00

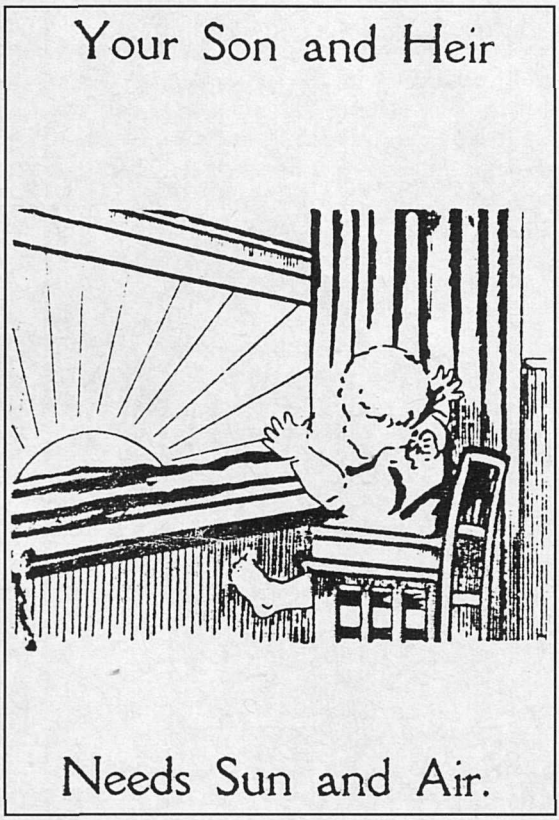
Public Health Education

Bermondsey and Drs Salter and Connan.

During the 1920's and 1930's Bermondsey underwent enormous social reforms under the leadership of Dr Alfred Salter. This remarkable man, an outstanding graduate of Guy's Hospital, committed himself to the people of Bermondsey and served them as both Medical Practitioner and Member of Parliament for West Bermondsey between 1922 to 1945. Following Dr Salter's election, firstly to the Borough Council and then shortly afterwards to Parliament, the Bermondsey Borough Council inspired by his zeal and; under the leadership of Dr D M Connan, initiated the first coordinated community health education project in the country. In this brief account the methods and ingenuity of the propaganda section of the Public Health Department are outlined. By all accounts these concerted attempts at health education were largely responsible for the remarkable transformation in the health and hygiene of the local community documented to have occurred by Dr D M Connan, who was at this time the Medical Officer of Health for Bermondsey and Lecturer in Public Health at Guy's Hospital.

The propaganda section was formed in mid-1924 by the Public Health Department and coordinated by Dr Connan. Their aims were firstly to educate the community and the individual in the nature of disease, precautions to be taken to prevent the spread of disease and the limitation of developed disease. The diseases included in the original manifesto published in the *Municipal Journal and Public Works Engineer*, November 7 1924 were 'infectious diseases, tuberculosis, rickets, rheumatism, heart disease, venereal disease, diabetes (Insulin), the common cold, food poisoning and flies on food'. In addition, in the broader sphere of social and industrial conditions appropriate to Rotherhithe and Bermondsey in the early part of this century were, 'housing/light, ventilation, affects of damp, drains, house inspection, industrial disease, precautions taken in factories and the reasons for them'.

Following on from this, the scheme submitted to the Bermondsey Propaganda Department in mid-1924 embraced various methods of health education including leaflets, advertisements, electric signs, town hall lectures, open air demonstrations and the establishment of a central office of information. (This central office was to play a critical role in coordination which was fundamental to the success of this operation).



An example of the posters used in the campaigns.

The leaflets were short with fairly large print, illustrated and covered not more than a single page. Over the decade thousands of these leaflets written by the Medical Officer, were distributed yearly. There were at least thirty titles ranging from babies, bugs and breast feeding to scarlet fever, scabies and smallpox. These leaflets were generally well written and medically informative, always conveying the necessary facts with self-help points. They were mainly distributed at open air demonstrations and town hall lectures. Further to this other sources included the sanitary inspectors, health visitors and tuberculosis nurses who as Dr Connan comments 'have many opportunities to greatly increase their circulation'. Posters were ubiquitous and displayed in the council sites and on

Face has lost its healthy glow,
Mind and memory are slow,
Life is one long tale of woe,
Constipation!

council buildings. Illustrated posters were preferred with simple and straightforward subject matter. Sandwich men were also employed on occasion to increase public awareness in areas that were considered lacking publicity. In addition there were advertisements in weekly newspapers advertising public lectures, open air demonstrations and hours of attendance at various clinics under the control of the Borough Council; and also at the central office of information. As the scheme developed, a short article on public health subjects written by the Medical Officer of Health, appeared in the local newspapers concurrently with the advertisement. The article would invariably deal with the same subject matter as the public lecture or open air demonstration given in the Borough during the week.

A particularly curious form of propaganda used were the electric signs, installed at many sites belonging to the council. In Bermondsey the first electric sign of this kind was installed outside the Grange Road public convenience. The sign showed twelve pictures and was illuminated from seven in the morning to eleven in the evening. The first series of pictures made by the Propaganda Department, by way of illustrations, dealt with the neglect for teeth. The illustrations were simple, explaining themselves, and to each picture was attached four lines of doggerel verse. The signs, as one might expect bearing in mind the novelty of such items, attracted considerable attention in the Borough and were certainly seen by large numbers of people. Unfortunately the spectacular signs were only used for six years before being abandoned, the reason for which is unclear.

Also of interest were the open air demonstrations which centred around the Cinematograph van. This remarkable vehicle previously existed in its former life as a disinfecting van before being especially adapted for this purpose. The back of the van was replaced by a screen, onto which pictures were thrown from a machine placed above the drivers seat. A series of lantern slides (ten to fifteen in number) were shown to begin with and while these were on the screen, the lecturer explained to the audience the purpose of the demonstration; dealing with each slide and its subject matter, amplifying his remarks by reference to the film which was shown immediately after the slides. Most of the talking was done while the slides were being shown, as the film itself had printed matter explaining its own subject. During the 1920's there were few if any health education films available to either purchase or hire and therefore the propaganda section used their considerable talent and initiative to direct and produce these health propaganda films written mainly by Dr Connan. In total sixteen of these films were produced and they were so successful that many were sold to other county councils in the Midlands and North of England and three films were sold to foreign governments. (Three of these films survived and have recently

been converted onto VHS format for video use, at the John Havard local history library in Borough High St).

The *Municipal Journal* records Dr R King-Brown, the Medical Officer of Health, who comments 'considerable difficulties have been overcome in adopting the van and, although the result is quite good and frequently attracts audiences of two to three hundred at a time, there are certain limits to what can be done with an improvised van. Undoubtedly a far better result could be obtained with a van especially constructed for this purpose'. The impression formed from these comments is rather understating the novelty and improvisation of this remarkable vehicle! On Saturday October 4, 1924 the Cinematograph van was given its screen debut. Infact three open air demonstrations were held at different places in the Borough dealing with the subject of teeth. A total of between seven and eight hundred were addressed during a single afternoon.

Every street corner in turn became its own cinema with the arrival of the Cinematograph van. The original disinfectant van which had improvised well was eventually scrapped in the 1930's. By 1936 well over four hundred of such lectures had been delivered. The number of lectures given in any particular year depending upon the nature of the weather.

The Propaganda Department believed adamantly that if a publicity campaign was to be of any use at all, there must be careful coordination so that town hall lectures, open air demonstrations, newspaper advertisements all dealt with the same subject simultaneously. At all times the department were very keen to gain the cooperation of the local people in its work, which they achieved with considerable benefit to the health of the Borough. Individuals were recruited to rally support for the town hall lectures held in the Bermondsey Town Hall. The lectures were given by well known persons, local and national figureheads, including Dr Alfred Salter MP.

In this brief descriptive account of the methods of health education used by the Bermondsey Public Health Department little attempt has been made to evaluate the results. However, there can be no doubt that the outstanding pioneering work of the propaganda section played a significant role in reducing the mortality and morbidity of the local population and made for improved standards of personal hygiene. By way of example, aside from the councils large scale demolition of crowded unsuitable accommodation; the health education concerning the spread of disease and need for isolation of active cases along with the advertising and distribution of TT (Tuberculin tested milk) were certainly important factors in reducing the death rate from tuberculosis. Infact in the ten year period from 1924–1934 the average death rate fell from 1.7 per thousand in the preceding ten years to 1.2 per thousand.

Also of interest with regard to tuberculosis was Dr Salter's successful cam-

paign, firstly to send tuberculosis bone cases to Switzerland at public expense and further to this to establish the first municipal solarium in Britain at the Grange Road site. The propaganda section were utilised to maximise the resources with thousands of patients treated in the solarium suffering from a variety of conditions. Dr Salter reports in July 1927 after the solarium had been opened for a year: 'wonderful cures are being effected under the skilled direction of Dr Connan: miserable ailing children, delicate anaemic and flabby are being turned into plump, rosy cheeked youngsters full of life and spirit. Terrible lupus ulceration is being eradicated and soundly healed. Tubercular discharge from bones and joints are dried up, large glands in the neck subside and disappear. The treatment was aslo found of great value for other diseases; rickets, psoriasis, neuritis and some forms of chronic rheumatism and other diseases are also being treated in many cases with great and growing success'. This appears to be the first documented account of successful ultraviolet light treatment for rickets and psoriasis.

Finally the improved standards of community and individual hygiene were largely due to the enthusiastic health education campaigns. Much of this success was achieved within the schools where hygiene lectures became a regular feature of school curriculum given by the doctors and staff of the Bermondsey Public Health Department. These lectures were invariably illustrated by lantern slides and films described earlier.

In conclusion, during the 1920's and 1930's since the original hygiene crusade 'scheme' was drawn up, the educational work certainly became an integral part of Bermondsey's public health department. Indeed many of the health education methods described here bear testimony to their outstanding work which has rarely been rivalled to this present day. At this point it is appropriate that Dr Connan should have the last word on the matter. In concluding his MD thesis on the work of the Bermondsey Public Health Department he writes 'to the politician, opportunist and evolutionist as he usually is, the hope of the future lies in education'.

Tim Illidge

The Rheumatology Unit

A short account of current research

Rheumatic diseases are one of the major causes of morbidity in the community and account for a significant proportion of the work load of a general practitioner. The Rheumatology Unit, in addition to providing a comprehensive clinical service in outpatient and inpatient rheumatology, is heavily engaged in several aspects of rheumatological research including hypermobility syndromes (Professor R Grahame) and metabolic bone diseases (Dr T Gibson). This article, because, of limitations in space, will concentrate on the research into the cellular immunological and immunogenetic aspects of rheumatoid arthritis (RA) and the way in which such research can be translated into new therapies (Professor G S Panayi, Dr J S S Lanchbury and Dr Gabrielle H Kingsley).

RA is a common disease with prevalence in the population of some 3 percent. It is characterised by an inflammatory, destructive and erosive polyarthritis in the synovial joints and a multiplicity of extra-articular features. Although the cause is unknown much progress has recently been made in our understanding both of the genetic basis as well as the immunopathogenesis of the disease. Family as well as twin studies have show that the disease has a weak but definite genetic component which interacts with yet unidentified environmental factor(s). Serological studies, in the late seventies, established a genetic link with the HLA system and, in particular, HLA-DR4 (1). Subsequently it was shown that there are a number of DR4 subtypes characterised by differences in amino acid sequence. Two particular subtypes, DW4 and DW14, were shown to be associated with RA whilst another, Dw10, was not and may even protect against the development of RA. This distinction was made by amplification of the DR4 β gene using the polymerase chain reaction (PCR) following by gene sequencing (2, 3). The amino acid substitutions in Dw10 are non-conservative and are thought to interfere with or alter the function of the HLA-DR4 molecule. HLA-DR molecules present antigenic peptides to cells which are then activated to initiate the inflammatory cascade operationally defined as cell-mediated immunity. Active work is in progress in the Rheumatology Unit to characterise the possible auto-antigenic peptides being presented by HLA-DR4Dw4 or HLA-DR4Dw14.

Another very active area of research is the cloning of the T cells from the rheumatoid joint which may be responding to the 'rheumatoid' antigen so that the genes for the T cell receptors (TCR) can be cloned and sequenced.

It will be readily appreciated that, based on the genetic association of RA with HLA-DR4 and the known function of HLA-DR molecules which is to present antigenic peptides to T cells, T cells are posited at the apex of the inflammatory process(es) which leads to joint destruction. Immunohistochemical studies of the synovium (4) and analysis of single cells by cytofluorographic examination using monoclonal antibodies have revealed that the majority of the T cells belong to the 'helper' variety and to the so-called memory sub-population which contains T cells responding to recall antigens such as tetanus toxoid and tuberculin PPD (5). A major effort in the Rheumatology Unit at present is devoted to defining the antigen specificity of T cells not only in the joints of patients with RA but also in those of patient with Reiter's syndrome following urogenital infection with *Chlamydia trachomatis* (6). In addition to antigen-specific responses, memory T cells may be activated by non-immunological means such as adhesion to endothelial cells, interaction with activated macrophages and by binding to connective tissue matrix components such as fibronectin. Cytological, functional and molecular biological techniques are being used to study not only the mechanisms but the consequences of these different types of T cell activation.

One long term goal of these studies is the development of more specific, less toxic and more effective therapies. The Rheumatology Unit was amongst the first to use anti-T cell monoclonal antibodies (mAb) for the treatment of RA (7) and these trials are continuing with an anti-CD4 mAb directed against helper T cells. Furthermore, the Unit has underway a study in which chemically modified T cell clones, grown from the rheumatoid joint, are being used as an autologous 'vaccine' in patients. This study is at too early a stage for firm conclusions to be drawn but T cell 'vaccination' appears to be non-toxic and not to worsen disease.

Thus, in summary, the research aims of the Rheumatology Unit are to acquire knowledge at the *laboratory bench* which can then be applied as therapy at the *bedside.*

Professor G S Panayi
Dr Gabrielle Kingsley

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The Guy's Hospital Gazette would welcome further short reports about the clinical research activities of departments within the Hospital.

Ideally the article should be typed and be double-spaced. Copy should be sent to us at Boland House.

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Working With Mr Jacobson

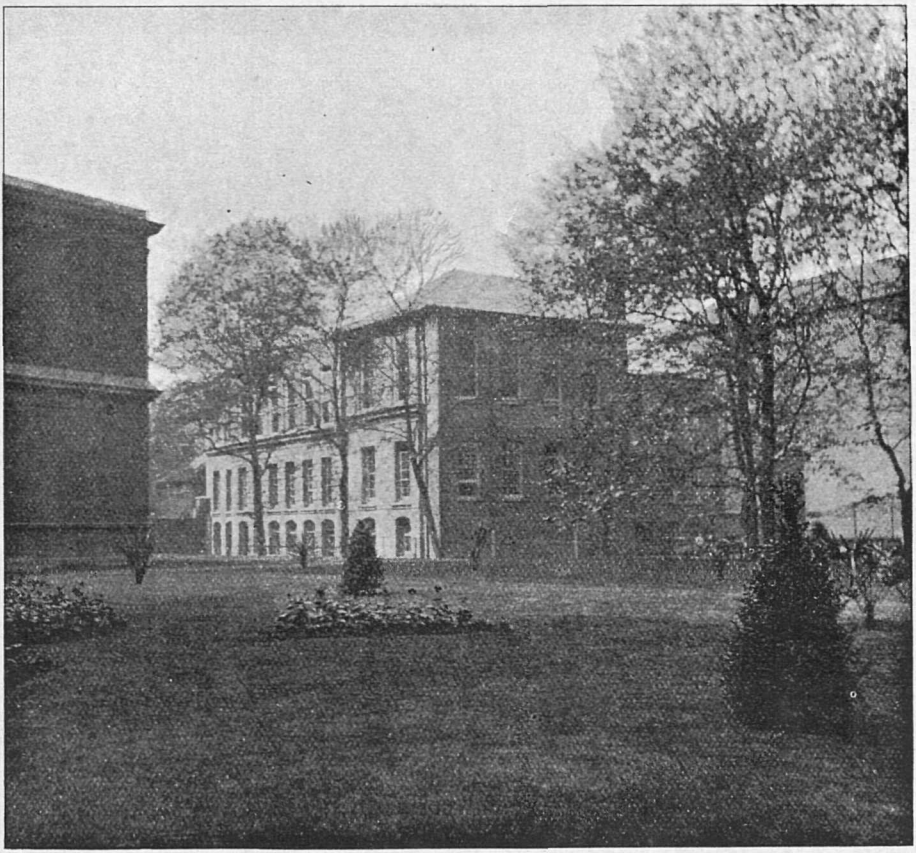
Life as a ward clerk in 1900

On January 1 1900, I commenced my appointment as one of two ward clerks to Mr Jacobson. No one who ever worked under that outstanding figure, and I was successively his ward clerk, his dresser and his House Surgeon, would, I venture to think, dare to omit the Mr, and I shall refer to him in these notes as Mr J—the abbreviation he himself always used when he dictated the notes of an operation of one of his clerks.

The surgical ward clerks had had an hour's instruction a day or two before from the kindly but exacting Registrar, McGavin—he was of course the only one in those days—and had furnished themselves from a small shop in Newcomen Street with a case of instruments and a battery of four 3-minute thermometers. Our day in the wards, Naaman and Dorcas with some accidents in Cornelius and Astley Cooper, commenced as soon after nine-thirty as possible. Between nine and nine-thirty we should have attended Bellingham-Smith's classes in practical morbid anatomy or Lauriston Shaw's demonstrations on recent specimens from the PM room.

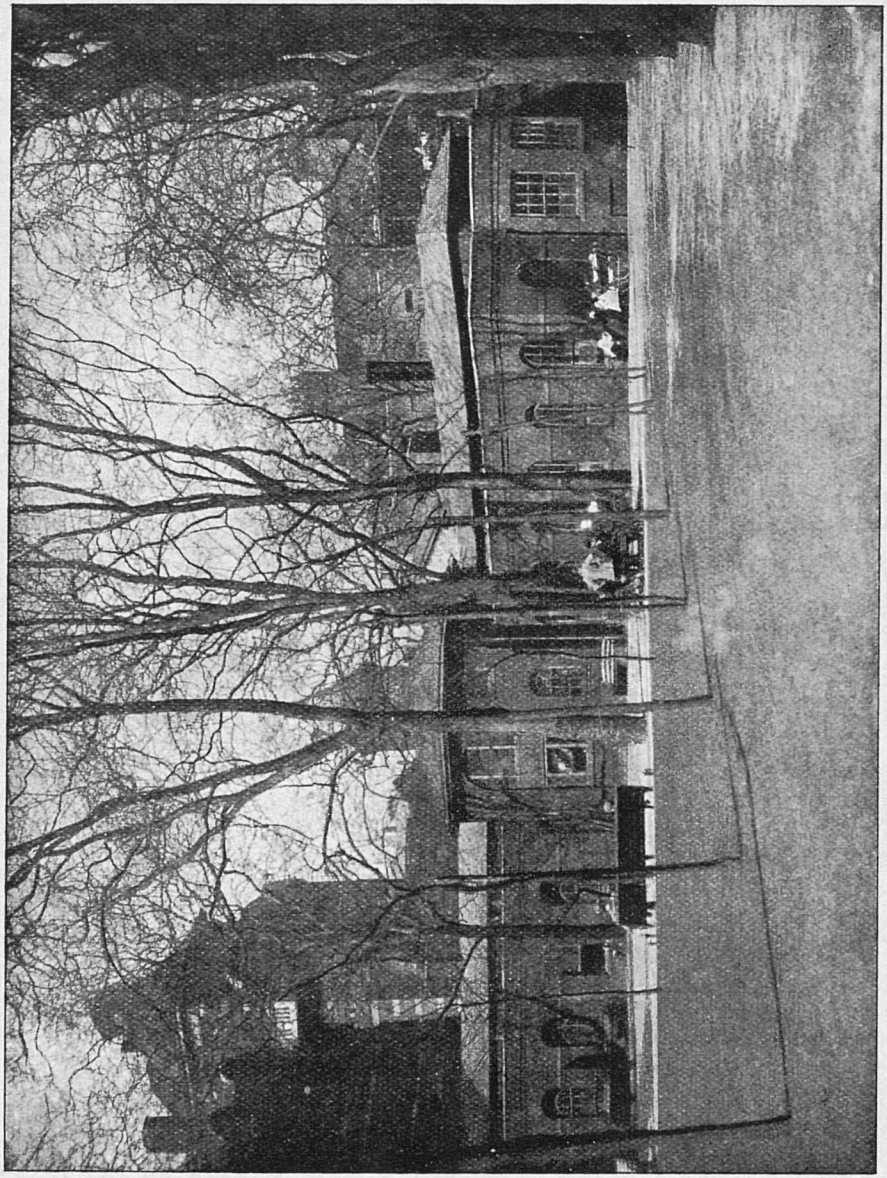
One's first duty was to take the temperatures. The ward clerks were responsible for the morning and evening temperature of any patient who was not on a four-hourly chart. Next, if a new patient had come into one of his beds overnight, the clerk had to hurry to get some notes written for McGavin, who might arrive at any time after ten o'clock. The rest of the morning was spent either in helping the dressers or in going round with the Registrar.

Regularly at one-thirty on four afternoons a week Mr J arrived at the hospital. He came usually in his victoria but he often walked from his house in Great Cumberland Place. Running up the steps and darting into the staff room, he would sometimes have a hurried lunch of sandwiches and a small glass of Australian burgundy. Before an operation the two ward clerks carried the patient on a hand stretcher from his bed to the theatre and also two buckets, each filled with Lysol, one containing gowns for the dressers and the other one towels for the operation. Then they had to get the instruments from Coles, who sterilised them in the old theatre, in a tray containing 1 in 40 carbolic lotion, together with



Above is The Park at Guy's, as it appeared in 1897. The building on the left is part of the old Medical School, and contained the museum and dissecting room.

silk and salmon gut. The Ward Sister or Head Nurse accompanied the patient, but there was no Theatre Sister or staff of theatre nurses; one nurse only was on duty in the 'mackintosh' room and she never attended an operation. Both dressers and ward clerks were long mackintosh coats with short sleeves gathered in by elastic which gripped the arm just above the elbow and over this those immediately assisting put on gowns soaked in Lysol. Mr J alone wore a dry, sterilised sort of



The Old Clinical Wards (demolished in 1919)

pinafore with short sleeves tied above the elbow. After scrubbing with soap and water the hands and arms were wiped over with turpentine before a thorough rinsing in Lysol. Rubber gloves did not, I think, come into general use until some six years later. The patient's skin was similarly washed over with turpentine and lysol and the operation area surrounded with towels wrung out of Lysol. No catgut was ever used, as all methods of sterilising it were distrusted. Silk was used exclusively for ligatures and deep sutures with interrupted salmon gut stitches for the skin. I never saw Mr J use a continuous horse hair suture and Michel's clips were not invented until many years later. At the completion of the operation the wound was dusted with sterilised iodoform or xeroform and over it was placed a piece of green protective—green oilsilk—a real Listerian relic. This was followed by double cyanide gauze and lastly by iodoform or salicylic wool, the purple gauze and primrose yellow wool making an effective colour scheme. The anaesthetic, given almost always by the House Surgeon, consisted of ACE with a Silk's mask (there was no premedication) often followed by ether, for which either an Ormsby or Clover inhaler was used. Sometimes Mr J would demand chloroform: 'Now that the veins are well filled with ether, Mr Anaesthetist, you can safely give some chloroform'. For this latter Junker's apparatus was generally employed. I expect there was more post-operative morbidity, more bronchitis or occasionally a bronchopneumonia, than there is to-day, but I never saw a death under an anaesthetic during my time at Guy's.

For a ward round Mr J always had a large following, as he was generally considered the best teacher of surgery in the Hospital. On such occasions the atmosphere was usually stormy with some striking gleams of sunshine. His teaching always took the form of question and answer; and the questions were often unexpected. 'What would Sydney Smith say if he saw a woman like that?' as he pointed to some stout patient. No one of course was sufficiently acquainted with the *dicta* of the ecclesiastic to provide the answer. 'It would be a good morning's walk to go round her waist, sir; you would have to read the Riot Act to disperse her.' Or, commenting on the misuse of a fomentation, he would again paraphrase Sydney Smith—'You might as well foment the dome of St Paul's to please the Dean and Chapter.' I remember one question he posed to which even his own answer was not altogether satisfactory. 'Why,' he asked, 'is the transverse colon near the stomach?' No one knew any embryology to speak of in those days and all were dumb. 'One can only suppose,' Mr J would answer, 'that a beneficent Providence had a very good reason for placing the sluggish colon next to the actively contracting stomach.'

In Naaman and Dorcas surgical tuberculosis took up very many of the beds; tuberculous glands in the neck, in the treatment of which Mr J was fond of quoting Professor Mickulicz, 'Treat them as if they were malignant and let your

first operation on any case be your last'; tuberculous joints, which were either erased or excised; and tiresome sinuses, which were repeatedly curetted. In Naaman there were always four or five cases of impassable urethral stricture: Mr J was an adept at performing Cock's operation. Otherwise there were the hernias, an occasional thyroid, cancer of the tongue and breast or a renal calculus. During my time as a ward clerk I think I saw one appendicectomy, but I never saw the abdomen opened otherwise, as all acute abdominal conditions were admitted into Clinical and the more chronic ones into the medical wards. Occasionally operations were performed in the ward. I remember Mr J tying the common carotid for a secondary haemorrhage in the patient's bed in Naaman and doing a cleft palate in Dorcas. Among the many differences in treatment fifty years ago compared with to-day, two stand out. First, the time patients were kept in bed after any but the most trivial operations—the appendicectomy was not allowed to sit out of bed for six weeks— and again, the amount of alcohol ordered. In Naaman one not infrequently saw a man enjoying a pint of stout or ale, two ounces of brandy and three of port each day.

Take-in week was then, perhaps it is still, a great occasion for the firm. The two dressers for the week, who had bedrooms just above the dressers' room, provided out of their own pockets the material for tea and supper for the seven days. This consisted of a barrel of beer, a ham, tinned tongues and sometimes a cold sirloin, as well as bread, butter and jam. To the best of my recollection all this food and drink cost each of the two dressers only about twenty or twenty-five shillings. To these meals in the dressers' room all old members of the firm were welcome. I remember seeing more than one Khaki-clad figure at supper there just about to sail for South Africa. The dressers also produced an often finely designed and cleverly drawn advertisement, which was hung up in its frame in the Front Surgery and in which was set out the names of the members of the firm and at the end of the week the number and nature of the cases admitted. My abiding memory of those take-ins is the late hours we kept. I had a room in Zetland House for the week and I think we prided ourselves on staying up until three or four o'clock in the morning. There was certainly a great deal to be done and it seemed that nothing was ever commenced until after nine o'clock. Besides writing up one's reports for the Registrar, one was expected to help the dressers to put up fractures. For a simple fracture of the tibia and/or fibula—'When dressers talk of tibs and fibs and nurses talk of trachies' said Mr J, 'I go home,'—a Croft's plaster splint was the standard treatment. There was no prepared plaster bandages then and the performance began with baking the plaster and rolling the gauze bandages in it. As anyone will remember who was familiar with this splint, it required considerable concentration on its detail and speed in its application and there was a regular competition between firms to excel; the

Lucas dressers were considered by many, even outside their own number, to be the most successful in this matter. For fractures of the neck or shaft of the femur, Hodgen's splint was the routine. Another evening's entertainment the week provided for the ward clerk was in watching or helping dressers in their search for bits of broken needle in the sole of the foot or in the palm of the hand. X-rays were not used for this purpose and they had no other aid in locating the foreign body than the uncertain assistance of the telephone probe. The search was therefore often interminable. These activities would be interrupted about ten-thirty by the arrival of the Assistant Surgeon for the week, who also had a bedroom over the dressers' room and who saw the more serious emergencies. I have just said that X-rays were not used for locating broken needles; nor were they used for broken bones except, I think, in cases of *suspected* fracture. The department was then in its infancy and was not regularly resorted to by most of the surgeons; althought I expect Arbuthnot Lane made use of it before he operated on the failures of previous treatment.

Among many memories of Mr J his clinical lectures stand out. These were very popular, the Physiology Theatre being filled to capacity, and over them he took an infinity of trouble. I remember particularly two lectures on tuberculosis of the testis and epididymis and two on Lupus vulgaris. In both cases he gave everyone who attended them a lengthy printed *précis* of the lectures. Howse did the regular course of surgical lectures, for which we all had to be signed up and have our names taken by that solemn, imperturbable, unapproachable Janitor, who had the remarkable gift of putting the correct name to a face after only seeing it once.

Lastly, I have an enduring appreciation of the value of the appointment. After several years at Oxford, where one had done tolerably well, it was very good for one to put aside book-learning for a bit. But, very much more than this, its value lay in being under a discipline, in carrying buckets and patients and in preparing tea and supper in the dressers' room. If I was slightly shocked at first at finding myself something of a Helot, the Dean's words in my first interview with him should have forewarned me—'Pray remember,' he said, as he blinked, 'that at Guy's we pay only the very slightest regard to any academic distinction'.

And one last story about Mr Jacobson. Some two years before I came to Guy's I had heard him read a paper before the Oxford Medical Society. As he finished, he roundly rebuked the secretary of the Society, who had addressed letters to him at Guy's Hospital, London. 'I would remind your secretary that "London" is quite unnecessary: there is only one Guy's Hospital in the world'.

submitted by **Professor Leslie Le Quesne**

From Guy's To Cambridge

The alternative route

There are few who actually realise it is possible to go to Cambridge to do their clinical training from UMDS. In my year I was the only one from Guy's along with 4 from St Thomas' (OK, 5 from UMDS). The Cambridge clinical course requires a separate application and is open to anyone who has an honours degree and 2nd MB, ie Cambridge and Oxford preclinical students and any other medical students with an intercalated BSc. You read for the Cambridge medical degree MB BChir.

I wasn't sure what to expect on coming up to Cambridge. It is amost like starting over again; as not many of the students know each other from before. The intake is mostly from the Cambridge preclinical course (75%); however most students only really know other medics from their own college (about 3 or 4 each year). Where undergraduates at Cambridge tend to stick to their own college socially, when they come to the clinical course the focus tends to move to Addenbrooke's (partly due to their friends graduating and leaving). When I came up to Cambridge the main difference I found was that you had to join a college—St John's in my case. The college looks after your accommodation, gives your grant cheque, provides meals in terms of a canteen (Buttery) and a more formal Hall (where you have to wear gowns). It also provides all the sports clubs and societies you would like to join and helps you financially in terms of books, electives, conferences etc . . . (only certain colleges!). There are of course University sports clubs and societies if you prefer, or those on the Addenbrooke's site in the shape of a very good leisure centre. Most college accommodation is pretty cheap (compared to London) and is in the city centre, which is about 2 miles from Addenbrooke's; a bike or car are useful but there are more than enough buses which go there. You don't quite have the time to really take part in college life as an undergraduate would, but it really is up to the individual just how much to get involved. Cambridge has undergone a bit of a nightlife renaissance recently (the Corn Exchange is an established touring venue, the newly-opened Junction's well worth a few visits and the Arts Cinema's great), but don't expect too many late nights raving.

Regarding the clinical course here, it is 6 months shorter than other schools (2 years and 3 months). This is achieved as all the firms are much shorter in length and, therefore, more intensive. For example, there is only one Clinical Pathology course at Cambridge lasting 4 weeks as opposed to 2 courses of 8 weeks at UMDS. The shortened course here is, in my opinion, long enough: examining the format reveals that the dead wood found in other places has been hacked out. What is covered is a balanced set of the essentials required before qualification, something that Addenbrooke's as a 'normal' general hospital, serving a (reasonably) normal catchment population, can provide, whereas certain London hospitals cannot. Addenbrooke's is also a regional centre for many specialities; hence within the hospital will also be found the 'rare and exotic' cases beloved of textbooks. There is still an elective of 7 weeks which compares equally with other schools except the long elective at UMDS (one of the things I miss). We get a 2 week break at Christmas and Summer—gone are those long preclinical holidays. The teaching is split between Addenbrooke's and the peripheral teaching Hospitals of East Anglia, including Papworth. The teaching is generally very good and there is a lot of it. Lectures are generally integrated into the whole course, ie one day of lectures every 3 weeks.

The clinical school building is on the Hospital site. It contains the school office, library, lecture theatre, tutorial rooms, on-take rooms, pathology museum and students common room and bar. The library is open long hours (even Sunday) and is very well stocked in terms of periodicals and has good audiovisual facilities. The atmosphere in the school is very cosy and friendly; since the year is so small (100) and the final year leave in December leaving only two years behind. Most students therefore spend their spare time in the common room or in Poppy's: a health food restaurant next to the main canteen. There is no continuous assessment here; however there are end of firm tests throughout just to indicate your progress. There is also an informal assessment at the end of 6 months in medicine, surgery and therapeutics; the results of which you discuss individually with the dean and your clinical supervisor. Your clinical supervisor is normally a registrar, or in my case a senior registrar. He teaches you every week in groups of 4–5, over and above what you are doing currently and helps you to acquire the necessary clinical skills throughout your course. There is a matching scheme for house jobs when you qualify and it is possible to say which of the major medical/surgical firms you want to do in or out, ie which house job you want in or out of Addenbrooke's. They try to give you the Adenbrooke's job in the speciality you intend to follow as a career depending, of course, on your ability.

I moved to a clinical course similar to most in the UK except that very little time is wasted and you get to experience a very large range of specialities, albeit

briefly. The surroundings (colleges) are beautiful and the area so much quieter than that of London: which is not all that far away (an hour and a half by car or train). For me the move has been a very good one but something I would consider for a long time before taking the plunge. My case is slightly different in that I am on the MB/PhD program here. This involves an intregrated PhD into the normal clinical course, the whole thing lasting 5 years in total, which clinical teaching throughout. My first year is the same as everyone else, but then I leave to do my research for 3 years and come back to finish the final year of clinical training. If you are interested in an academic clinical career as I am, the MB/PhD is a good opportunity to get good research training and still maintain patient contact throughout the 5 years. It is of course a big commitment and you have to have a place on the Cambridge clinical course before you apply for it.

Moeen Panni

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The Kirkland Papers, by Arthur Crane, Published—Crane Press 30 South Street, Ashby-de-la-Zouch, Price: £14.99

The stimulus and source of much information for this book derive from a written social commentary maintained by successive generations of the Kirkland family from 1788 to 1930. The author used additional archival material to add flesh to the skeleton provided by the papers. The Kirklands were a medical family living in Ashby-de-la-Zouch and the opening chapter dwells on Thomas Kirkland, a surgeon born in 1722. He did not contribute to the family diary but his fame qualified him for regular attention.

The book is of interest at several levels. It offers in-sights of the mores and customs of 19th and 18th century England, and reminds the reader of how rudimentary were public health, transport and the rule of law just 150 years ago. Thomas Kirkland became a surgeon after an apprenticeship in Loughborough. He was humble, well read and enjoyed music. His contributions to medical literature were sparse but included in 1754 a *Treatise On Gangrene* in which he doubted the value of cinchona bark (quinine) for this ailment. He also wrote an essay on suppressing haemorrhage and the cure of diseases associated with fever. He was awarded an MD at St Andrews in 1769 but did not write a thesis. Accounts of patients who survived his treatment attest more to the resilience of Englishmen than the surgery. His most relevant claim on medical attention was his notion that a knowledge of both surgery and medicine was advantageous. However, his claim on fame was due to his appearance as a Crown witness. Keen to advance his position he was appointed doctor to the 4th Earl Ferrers, a disagreeable and possibly alcoholic member of the nobility who shot his steward. The good Dr Kirkland helped the wounded man to escape and tended him until death. Rather than conceal the circumstances or offer mitigation he contributed by his evidence to the hanging of the Earl. There is an account of the hangman quarreling in public with his assistant over the fee and of the customary dissection of the body at Surgeon's Hall before its display in an upright coffin.

The most engaging part of the book is this first chapter. However, the descendants of Thomas had their moments. Thomas Kirkland's son, Thomas John, was apprenticed to his father. He was an enthusiastic sportsman who enjoyed prize fighting. One of his daughters married a French prisoner of war. Thomas Smith was a son of Thomas John and naturally took up medicine as well as hunting foxes. His daughter married a surgeon who succeeded to the practice. Their daughter maintained the family papers until 1931.

The presumably abridged family notes are appended and include entries such as 'an earthquake on Nov 18 1795' and 'Mr William Miles robbed on Jan 19 1793'. However, of public health interest are reference to the reluctant application of the Poor Law Act (1836) and the building of town drains in 1853, 5 years after the Public Health Act. Before then the townsfolk habitually emptied their privy contents into the local stream.

In summary, an interesting and readable book. It would have benefited from greater continuity between the chapters and the inclusion of a family tree. I commend it to any reader with an interest in social or medical history or some connection with Ashby-de-la-Zouch.

T Gibson

Do Your Bit

As the new Guy's Campus President, my gratitude and thanks go to Richard Russell for all his hard work for the union last year. I will endeavour to fulfill the task as best as possible in the coming year. May I begin by introducing the other members of the Guy's Campus Committee for those who do not know already.

Vice President—Ed Sharples.
Treasurer—Simon Russell.
Bar Secretary—Steve Walsh.
Social Secretary—Paul Brain
Jnr Social Secretary—Anne-Marie Rees.

I look forward to working with them.

Congratulations to all those recently qualified doctors who by now I'm sure have settled into their wonderful new jobs. Good luck with those venfloms at 3.30 in the morning. (Student bleeps are in the rack by then—unlucky). Welcome to the new Clinical Students—your best year awaits you!

It seems appropriate, at this time of the year to address an issue which has concerned many people, and reached a point where I think we, as a student body, must act. It is that of the Freshers/1st years. All of us know, especially those who have organised social events that although there are a few 1st years who do participate in the social life at Guys, there is an increasing number who don't seem interested. In fact, this is a trend which has been getting worse over the last few years. Some people blame the Dean and the school entrance committee for choosing 'the wrong type of students'; others say that it is just the new generation of students. Perhaps. From a questionnaire I sent to the 1st year dentists and medics last term, we got the message that the social events 'are too much the same old thing' and did not cater for a wide enough taste in music for it to appeal. So we've learnt from that and new events, and ideas will be introduced by the Bar & Social Secretaries. Some will say that the drop in numbers attending social events is because not everyone envisages their social life as always going to the bar etc. Fair enough, so do I . . . to an extent. Personally I feel that part of the problem is the fact that a lot of new UMDS students have no loyalty to either hospital and so do not feel part of one particular school. Thus they don't feel obliged to show any committment.

Whatever the reason for this trend, I think that we are partly to blame as well. Could I ask that we all make an effort, no matter what year, to get to know as many freshers as possible. I know that many do so anyway, but let's give this Medical School an even better reputation for being a friendly place to come to, and not only because one plays sport or drinks 10 pints of beer! Freshers week will be held from 3 October until 11 October so take time off and enjoy it, as well as welcome the freshers. In this way they might feel included and show their faces more often.

Enough of that for now. If, at any time you have any problems, please do not hesitate to contact me via Boland House or in the spit.

Other news:—

- Students have requested a Sky Satellite dish in the TV room. Depending on Union funds we will do our best to get one installed.
- A pool table should shortly arrive in the bar.
- A brief newsletter containing all the social events of Guys and St Thomas's will be compiled next term.
- It has been decided, for financial reasons and for the sake of the 1st and 2nd years, that a joint Christmas Ball will

replace the Snowflake and Valentine's Balls at least this year.

- The UMDS united clubs AGM will be held on 21 Oct 5.30 in St Thomas's Hospital Bar. Please support this and voice your opinions.

Anyway, all the best with what ever you are doing.

Gordon Kooiman

New Doctors

The following students qualified MBBS (London) in June 1991:—

Abaecheta, Miss A-M N
Alexander, Miss E M
Ali, Miss S
Allan, B T W
Allen, Miss R L
Ames, W A
Barakat, K
Barrie M R
Basu, D B $
Batley, M A
Baxendale, Miss H E
Beasley, J V
Bennetts, Miss K
Birbeck, Miss C J
Bird, C F
Biswas, Miss T
Bowen, Miss J S
Brand, A J O
Bremner, F D M
Brooker, J C
Busch, C A
Buxton, Miss J R
Campbell, Miss L A
Chan, C L H
Chandr-Ruang-Phen, P *>
Chaudhuri, S
Child, Miss F J *+
Cieslicki, Miss S H
Coonar, A S
Cuff, Miss B E
Curtis, Miss V A
Cynk, M S
Daniels, Miss C M *
Dick, Miss A M
Dill-Russell, P C
Dobson, Miss J A
Dove, D S
Downs, A M R
Edynbry, Miss K D
Ellis, Miss C M
Evans, Miss M +
Farrington, A
Fogg, Miss C J
Fox, Miss E F
Frisby, P A
Fulford, P E
Gill, A D S
Gillmore, Miss A B C +
Gleeson, Miss C M A
Graham, J C
Grainger, M A
Gundry, Miss A C

Hall, Miss J L
Hall, N S
Hand, G C R
Hare, J M S
Harrison, Miss R L
Haughey, Miss N M
Heap, Miss E L
Hobbs, A M B
Hopkisson, J F
Horvath-Howard, P A
Jankowska, Miss A M +$
Kalairajah, M
Kamal, Miss D S *>
Kay, A D
Keating, Miss A R
Kellett, B C
Kelly, J A /
Kendell, Miss J $
Kett-White, C E R
Khan, Miss L N
Koppell, D A
Lawrence, Miss J S
Lee, Miss B T M
Lewis, J C
Lewis, Miss R J
Lloyd, G W L
Lockie, Miss S M C
Maini, R
Makings, Miss E A
Maudgil, D
Meeran, Miss J
Membrey, W L
Molyneux, P D *>
Monella, S C
Montgomerie, J
Moore, Miss P C L
Morris, J
Negus, Miss A S
Norwood, Miss F L M
O'Donnell, Miss C A-M
O'Dwyer, P
Oteng-Ntim, E
Paddon, A J +
Pambakian, Miss A L M /
Pao, S J
Parmar, S J
Patel, Miss N R
Patient, Miss C J
Paun, S H
Pereira, J A
Phillips, Miss J T
Phull, Miss N K
Planche, T D
Popovic, Miss S
Pritchard, Miss H I
Rees, Miss H L
Reeves, E R J
Rhodes, Miss A C
Roberts, C M
Robinson, Miss E K
Rose, J D
Rosell, P A E
Ross, Miss E C
Rutter, D A
Sadler, M J +/$
Sale, A C B
Service, Miss E
Simon, R D B
Simpson, Miss A C
Skelton, Miss V A
Slade, M G +
Smith, Miss S M E
Solomons, N
Stevens, Miss A M
Taggart, G E
Taylor, M J
Thomas, A W
Thompson, D
Ustianowski, A P D S
Versey, M J
Vijayanathan, S /
Wain, Miss C E
Watson, Miss J M $
Watson, M A
Webster, K
Wharton, R Q
Whelan, A P
White, Miss M

Williams, A B
Williams, A D
Williams, Miss C E
Wright, B
Yeung, Miss S M
Yu, D F Q C

The following students qualified MB Chir (Cambridge) in June 1991:—
de Souza, Miss V
Ford, H E R
Griffiths, M
Hatrick, A G
Heriot, A G +$
Jones, Miss R M
Manifold, Mrs N J
Ong, K L
Sargaison, Miss J M
Smith, Miss P J
Stenner, J M C
Stevens, T G
Stope, A F M
Teoh Leok Kheng, Miss K
Usselmann, B M
Vogelzang, Miss S A
Wheeler, Miss E J
Whitaker, Miss J M +
Wong, Miss I B Y
NB:
* Distinguished in Pathology
+ Distinguished in Medicine
/ Distinguished in Clinical Pharmacology
$ Distinguished in Surgery
> Distinguished in Obstetrics & Gynaecology

Dr M J Sadler BSc MBBS PhD also won the ICI clinical pharmacology prize at UMDS.

Dental House Surgeons

The following recommendations have been made to the Director of Dental Services for appointment of Dental House Surgeons for the period from 1st August 1991 to 31st January 1992,

RESIDENT including General Duties for

Mr Bret Day	—	Miss R V Phillips
Mr O'Driscoll	—	H Kumrai
Mr Gibb	—	C L Liu
Mr Haskell	—	N G Tomes

NON-RESIDENT including General Duties for

Immunology	—	Miss J C Smith
Oral Medicine, Pathology and Microbiology	—	Miss E H K Perera
Conservative Dental Surgery	25	R B Judge
	26	R Doshi
Orthodontics & Dentistry for Children	—	Miss S B Owen
	—	P M E Davis
Prosthetic Dentistry	—	Miss V J Kingsmill
	—	S J Thomas
Periodontology & Preventive Dentistry	—	Miss S A Orme

Rotating appointments with Conservative Dental Surgery & Oral Surgery

Rotation No 1	—	C S Huseyin
2	—	M Hekmat
3	—	Miss S Chauman
4	—	Miss S A Giles

Marriage

Dr Kate Laughton (Guy's 1990) married Dr Tony Gardner at Dulwich on 6 July, 1991.

Change of Address

Dr J E M Fox
5 Charles Fox Place
Auckland 5
New Zealand

Margaret Jones-Evans
2 Broughton Rd
Orpington
Kent

Dr W de Mello
22 Ashbury Drive
Hawley
Surrey GU17 9HH

Dr R G Cook
32 Hokianga Rd
PO Box 257
Dorgaville
North Land
New Zealand

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GUY'S HOSPITAL GAZETTE
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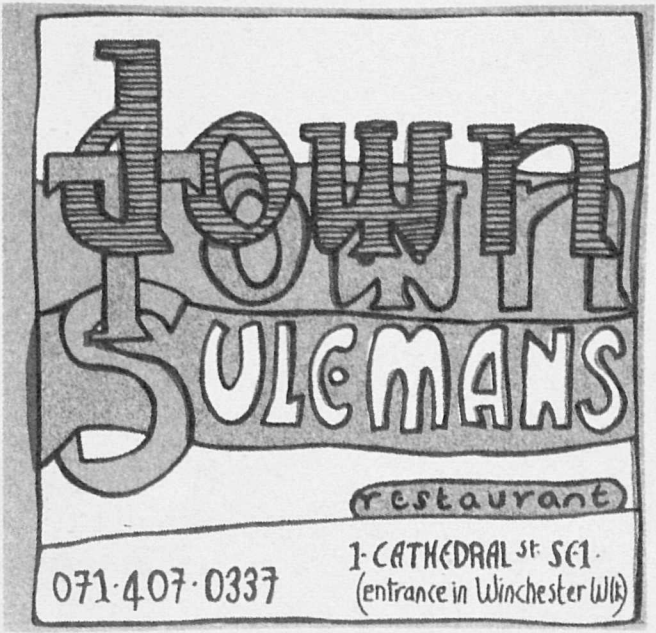

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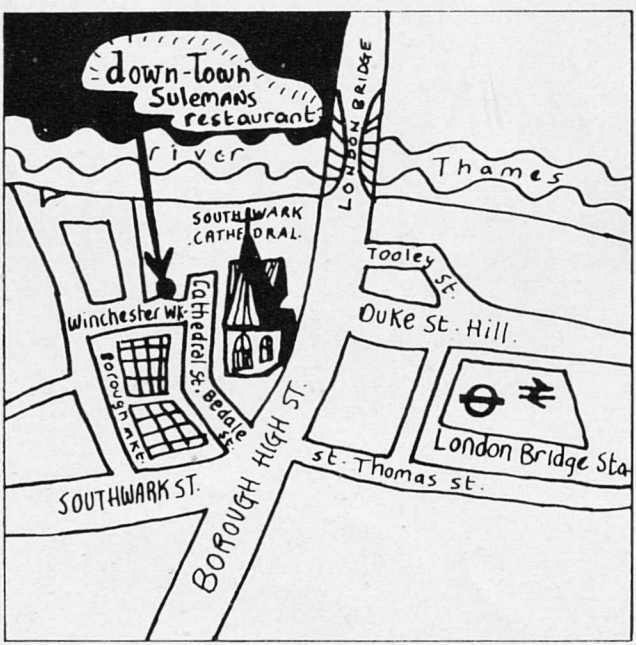

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Guy's Gazette

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Volume 105 Number 2416 October 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

In my first passim let me first of all thank Tim Plunkett and Alastair Santhouse, the previous editor and deputy editor. They have both been of tremendous assistance in the transition generally, and in the production of this issue in particular. I wish them all the best during their electives which they are spending in India. I look forward to their reports from the subcontinent.

I am delighted to have the opportunity to edit the *Gazette*—the oldest hospital magazine in the world. At this point let me welcome all the new students to Guy's and St Thomas's. I feel I can relate to your feelings of excitement and slight apprehension at the start of a new venture. If you would care to share these feelings, or alternatively if you would like to contribute in any way, photographs, articles, cartoons, production then please get in touch. The *Gazette* offices are on the first floor of Boland House and are open between 1.00 p.m. and 5.00 p.m.

Let me also welcome back all those who were away during the summer and introduce the newcomers to the editorial team. Hilary Martin will be the new Deputy Editor with News and Sport being edited by Shalid Khan and Abhimanu Lall respectively.

One final point is that tickets for the Gazette Christmas raffle are included with this months copy at a price of 50p each. Please return any stubs and remittance to the Gazette Office, Boland House, London SE1 9RT.

Future of UMDS

Dear Sir,

Both you Sir, in your *Passim*, in the August issue and Professor Haslewood, reflect the anxiety which many feel concerning the discussions which are taking place between UMDS and King's College regarding cooperation in undergraduate education, particularly but not exclusively during the preclinical period. We shall certainly pay attention to the points raised by Professor Haslewood and others during these discussions. Among the factors which have led the Board of Governors to encourage the discussions with King's are the changes which are bound to take place in hospital provision in London irrespective of which government is in power, and the changes in the content of the curriculum being recommended by the General Medical Council and on which you have commented favourably in a previous issue. In addition, whilst consolidating Anatomy at Guy's and Physiology at St Thomas's has undoubtedly been a success in strengthening both the teaching and research; it is now clear that similar consolidation for Biochemistry and Pharmacology on one or other site will prove very expensive and certainly at present is not affordable.

I am in no doubt that our first, but not only function is to provide the very best education and training that we can for our medical students and certainly this task rather than the need for excellence in research, desirable though this is, will dominate our discussions. In this respect we have to recognise that the split site solution between the St Thomas's and Guy's campus is not ideal and whilst it is theoretically possible for the whole of the preclinical school to be sited at either Guy's or St Thomas's, the cost of this would be absolutely huge and informal discussions have suggested that it is unlikely that the University or private donors will be able to provide anything like sufficient resources for this to be carried out. This of course is particularly so, given that King's College has purchased Cornwall House which is almost half-way between Guy's and St Thomas's at the south end of Waterloo Bridge (behind the National Theatre) and within easy walking distance of both campuses. The money for the rebuilding of Cornwall House to house the Life Sciences of King's College is available from the sale of various sites owned by King's College around London where aspects of their Life Science work currently takes place. If in due course we decide not to join with King's College for the teaching during the preclinical period, then we will have to have convincing reasons for the decision, bearing in mind that our students in moving backwards and forwards between St Thomas's and Guy's will be passing by the new Life Sciences building!

If these reasons for the discussions with King's seem somewhat negative, there are undoubtedly positive reasons for seeing whether this solution can be developed. Contemporary educational policy favours the concept of medical schools being part of multi-disciplinary universities because of the range of opportunities this provides for education and for research. It is more difficult now, though not impossible, to carry out relevant research in the Basic Sciences without a strong base because of the complexity of the questions, increasing sub-specialisation within the sciences concerned and the sheer cost of the equipment and materials.

If it is decided that UMDS should join with King's then there are a number of ways in which the risk of an impersonal

and unsatisfactory education can be avoided. For instance, we could develop a collegiate system whereby young women and men joined either St Thomas's, Guy's or King's as their main base, not only for social activities but also to link into the vertical integration between Basic Science and Clinical Medicine which is an important concept within the new curriculum. In addition, the staff in the Basic Science department could be attached to one of the three hospitals and be responsible for organising tutorials and developing the personal relationships between student and teacher which are so fundamental to a successful education. Given the convenience of Cornwall House to both St Thomas's and Guy's there should be no problem in establishing close links between Basic Science and clinical practice at our two main teaching hospitals. During the clinical period experience will be obtained not only at the students own teaching hospital and associated district general hospitals, but wider experience in more specialist areas will be available to all by utilising the specialist services which are likely to be consolidated at the three main teaching hospitals with less duplication than at present.

I would like to assure everyone that these discussions are taking place in a genuine attempt to improve our present arrangements, not out of fear concerning our survival. Much nonsense is currently talked about the closure of one or other of the three teaching hospitals in our neighbourhood. Whilst it is likely that hospital beds will be closed in South London and some hospitals will probably cease to exist given the discrepancy between the number of beds and the catchment population in London as compared with the rest of the country and the steady move to more outpatient treatment and short-stay admissions, nonetheless there is little reason to believe that this will lead to the closure of one of the main teaching hospitals. What, however, is clear is that the role of these teaching hospitals is bound to change and cooperation between each of them in provision of services as well as education and research will become more and more important.

Finally, I can assure both you and all your readers that the Principal and I as the Clinical Dean and the other School Officers are well aware of the anxieties that have been generated by these discussions. We are interested in everyone's view and whatever recommendations emerge from the discussions they will be fully debated by the School Management Board, by the Academic Board, by the students and all staff before a decision is finally made by the Board of Governors. Incidentally I agree with Mr Pryke that a UMDS crest combining elements of the venerable shields of both Guy's and St Thomas's is not a good idea. The School is proud to be associated with both hospitals and to be able to use both shields.

Yours faithfully,

C CHANTLER
Clinical Dean
UMDS

The Guy's Crest

Dear Sir,

I have just read in the August *Gazette* Mr Prykes letter concerning a proposed new Siamese-twin shield for Guy's and St Thomas's.

Your predecessor had the good taste last year to adorn the cover of our magazine with our splendid crest, a move very generally appreciated.

I am a Guy's man and shall always be a Guy's man and I don't want this proposed new Heraldic device, nor would the spirits of those commemorated on the War Memorial Gates.

And where are those gates?

I admire St Thomas's very much, my daughter trained there for her SRN and I played against their second XV in a cup final, but please don't give Garter King of Arms this horrible proposal.

I am sure that many will agree with me.

Yours faithfully,

GEORGE WESTON
115 Parkanaur Avenue
Thorpe Bay
Essex

Lessons From The Past?

Dear Sir,

You titled my letter in your August number 'In Defence of Guy's'. This was my intention, for the Medical School never needed its defenders more. The monstrous plan you mention by which King's College swallows up Guy's and St Thomas' to create a giant soulless factory for pre-clinical training is only the latest of post-war attempts to destroy the smaller London Medical Schools by imposing upon them fusion with one another or with Colleges of the University. The motive seems to be a mixture of bureaucratic dogma, empire-building and envy; no one complained about the quality (or cost) of Guy's doctors and dentists and the School strongly supported research from Guy's own funds. The Todd Report (1968) ordered Guy's to twin with King's at Denmark Hill, the two Schools to be integrated with King's College: it took months of work and much money for the two Schools to conclude that this was both impracticable and undesirable. A full revelation of what it cost to find the present solution for the Royal Free could cause a national scandal. Bart's has finally lost the best preclinical campus in London. The Flowers Report (1980) prompted the formation of UMDS (1982) in which Guy's has retained its Medical School, but for how long? The outcome depends on the will and courage of those who care.

Yours faithfully,

Prof G A D HASLEWOOD
28 Old Fort Road
Shoreham-by-Sea
Sussex

Ecclesiastical First Aid

Dear Sir,

Now we are in the Decade of Evangelism I think it is safe to mention part of a sermon delivered by my local Vicar only a few Sundays ago. He was talking of Weddings he had officiated at and the sort of things that might go wrong. One bride, he told us, had fainted during the service and he, stout fellow, had immediately loosened her clothing and laid her on the front pew. That's how he said it. I turned to my companion and whispered: 'He laid her on the front pew. Golly!' The ramifications of his actions clouded my concentration for the rest of the service. I am awaiting further revelations.

Yours faithfully,

Dr J H PITT-PAYNE
12 Top Park
Beckenham
Kent

Thank You

Dear Sir,

May I please use your columns to thank all those who contributed to the magnificent presents given to my wife and myself on the occasion of my retirement from the Dental School.

Yours faithfully,

A H R ROWE
137 Sydenham Hill
London SE23

Another Thank You

Dear Sir,

I would like to thank all my friends and colleagues for their lovely gifts and good wishes on my retirement on Friday, 9 August, having spent 20 years between St Olaves, New Cross and lastly on John Ward at Guy's. My special thanks to Sister Debbie Lamptey and her husband for all their hard work in preparing my wonderful party, and of course to Dr Roger Lewis for his very kind speech which was much appreciated.

Yours faithfully,

Mrs ROSE SMITH
73 Gosterwood St
London

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Dystrophin Advance

The UMDS Department of Experimental Pathology has had a recent publication in *Nature* concerning human Dystrophin Gene Transfer. Dr George Dickson, working under Professor Frank Walsh has managed to produce a cDNA construct of the Dystrophin gene from several sub-clones. The plasmid containing this gene construct has been taken up into mouse muscle cells and expressed. The method of expression of the gene is very inefficient at present since it is not yet incorporated into the host genome. It is however an important step since it is the first example of the stable transfer and expression of an engineered gene encoding recombinant human dystrophin. Further work will allow the proper evaluation of gene transfer as a real therapy for Duchenne Muscular Dystrophy.

Professor W J B Houston

Professor W J B Houston, head of the Department of Orthodontics and Dentistry for Children at UMDS has died tragically while on a climbing holiday in Switzerland. His body was found on 17 August but he had been missing for almost two weeks. He was climbing in the Chateau d'Oex area near Gstaad. Professor Houston was a very experienced mountaineer.

There will be a memorial service in London at Southwark Cathedral on Tuesday 12 November 1991 at 11.00am. Anyone wishing to attend this service should write to Miss Ann Taylor, UMDS, Floor 22 Guy's Tower, Guy's Hospital, London Bridge SE1 9RT for further details.

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Professor Roger Warwick

It is the sad duty of the *Gazette* to inform readers of the death of Professor Roger Warwick, Emeritus Professor of Anatomy to the United Medical and Dental Schools of Guy's and St Thomas's Hospitals.

Brooke Lodge—New Look

Brooke Ward officially marked its change of name to Brooke Lodge on 10 September following the completion of its art project. A group of artists known as the House Artists Co-operative worked closely with staff and patients to design a more stimulating environment in which to live and work. The ward is now painted blue and possesses a ceiling sculpture consisting of 14,000 butterfly shapes hanging from wires. This sculpture which was designed around the theme for the four seasons now provides a talking point for staff, residents and visitors alike, and in consequence relatives have found that they appear to be staying longer on visits. Measurements have also shown that the light levels in the ward have increased following the redecoration. Sir Philip and Lady Harris visited the patients, staff and artists during the open day.

Sir Philip and Lady Harris at the opening of Brooke Lodge

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Professor Malcolm Neville (Tony) Naylor

An appreciation

Professor Naylor will retire on 30 September this year completing thirty two years at Guy's. He has had a most varied career—from naval rating to University Professor.

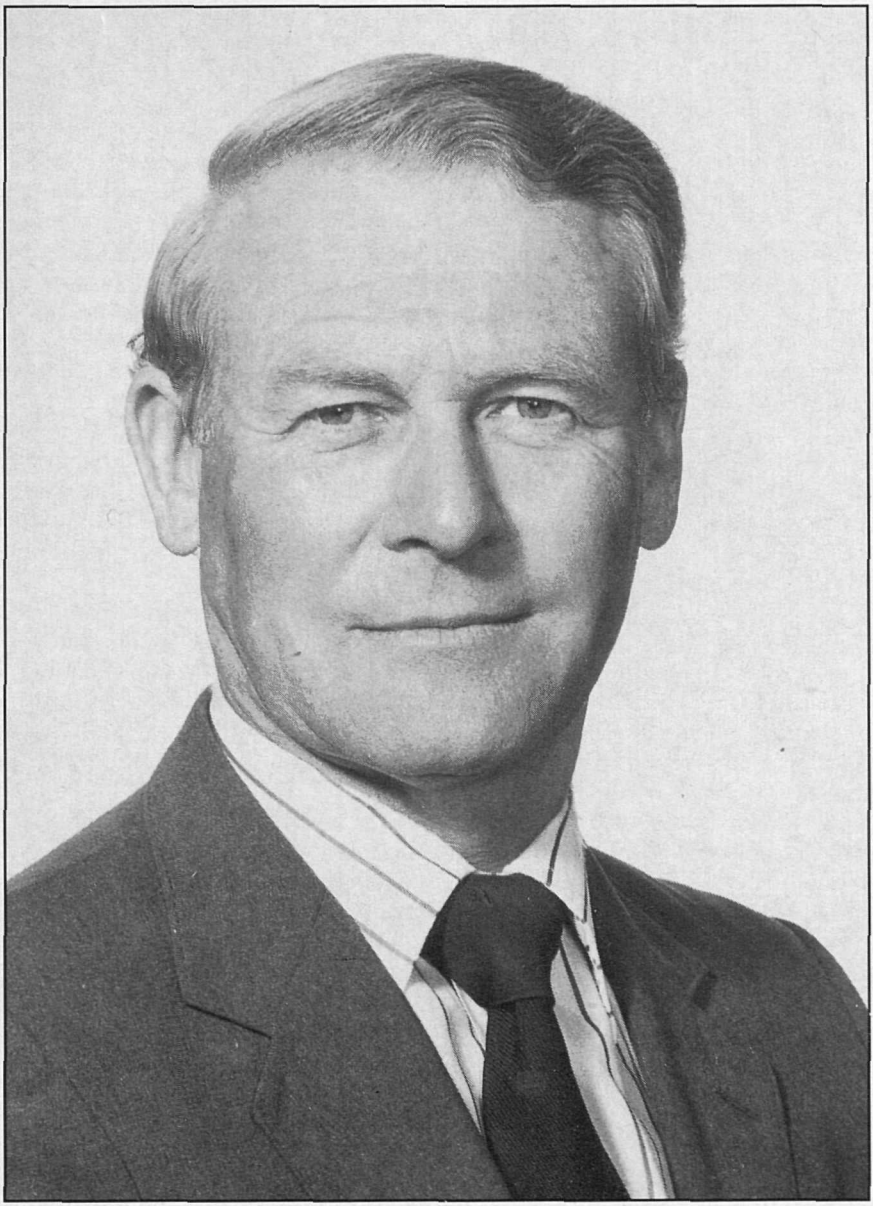
After war service he studied dentistry at the University of Birmingham where he gained distinctions in medicine, surgery, general and dental pathology and bacteriology in the LDS of the University in 1954 and passed the BDS in 1955. During the dental course he intercalated a BSc degree in physiology which was to be so valuable to him in his research career. It also enabled him to meet his future wife, who was his tutor in physiology. He obtained the Fellowship in Dental Surgery of the Royal College of Surgeons of England in 1958.

After working in the Dental Schools of Birmingham and Dundee he was appointed as the Dental Research Fellow under the late Professor Rushton in the department of dental medicine at Guy's. He held this post from 1959–1962 where he did much of the work leading to the award of the PhD of the University of London in 1963. In 1962 he was appointed a senior lecturer in the department of preventive dentistry. Promotion followed rapidly and the title of reader in preventive dentistry was conferred in 1966 and a personal chair was granted in 1970. In 1980 he succeeded Professor Emslie as head of the department of periodontology and preventive dentistry.

Professor Naylor has published widely and has attracted large research grants particularly for his work on fluoride in caries prevention.

He has made considerable contributions to the dental profession. He was Scientific Assistant Editor of the *British Dental Journal* from 1961–1980 and still serves on the Editorial Committee. For these and other services to the profession he was awarded the Tomes Medal of the British Dental Association in 1987. He played an active role in planning the dental services at Thamesmead and served on the BSI Committee preparing a glossary of dental terminology as well as being one of the key workers in the production of the report by the Royal College of Physicians entitled *Fluoride, Teeth and Health.*

Professor Naylor's organisational and research abilities have been recognised by the British division of the IADR. He was Honorary Treasurer from 1975–1990 and is currently President, an office he holds until 1992. He served as Secretary of the Board of Studies in Dentistry of the University of London from 1983–1986,



Deputy Chairman from 1986–1989 and is currently Chairman. He has also served as President and Secretary of the Odontological Section of the Royal Society of Medicine.

His service in the Navy during the War has led to a number of important posts. He served in the RNR from 1954–1977 and retired as a Surgeon Captain (D) and Honorary Dental Surgeon to the Queen. In 1967 he was awarded the Reserve Decoration. In 1979 he was appointed by the University of London as Honorary Colonel of the Officers' Training Corps. His wide knowledge of service matters made him an obvious choice for the University's Military Education Committee which he joined in 1975 and has been Chairman since 1979. He was also appointed to the Council of Military Education of Universities of the United Kingdom and was elected Chairman from 1983–1989.

Apart from organising a busy department in the Dental School, and personally undertaking the dental care of many patients, Professor Naylor serves as Chairman of the Dental Academic Committee and the Dental Funds Committee and is also Chairman of the UMDS Workshop and Computer Committees and is a Governor of UMDS. He has always supported student activities, in particular anything musical and will even participate on the cello if pressed. This interest in student affairs goes back to his own student days when he was President of the British Dental Students' Association.

A busy man always has time to take on additional responsibilities and Tony Naylor is no exception. Amongst his other activities he is a Lay Reader in the Church of England, a memeber of the Southwark Diocesan Synod, Chairman of the Board of Governors of St Saviour's and St Olave's Schools and a Governor of Whitelands College, Roehampton Institute of Higher Education and Bacon's School. He has recently been invited to serve on the Council of Sussex University.

Tony Naylor copes with all these activities in a very relaxed manner and also has time to discuss research or clinical problems with colleagues.

It is to be hoped that he will find time in what promises to be a busy retirement to pursue his many hobbies, including spending time with his son and family. His son qualified in medicine at Guy's and practises in Chichester—conveniently near where Professor Naylor moors his boat.

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Outline of the BMS Course

What to expect

We have written to the pre-clinical departments asking them to write a resumé of what to expect from the course. These courses are continually under review and we would always be interested to hear your views of them as you progress through the system.

Anatomy and Cell Biology

The course in Anatomy is sub-divided into topographical anatomy, histology (general tissue and organ structure), embryology (developmental anatomy) and neuroanatomy (the structural organisation of the peripheral and central nervous systems). We teach these subjects in lectures, practical classes and tutorials.

For the first five terms of your course, you will attend the dissecting room for two periods each week to dissect selected regions of the human body, and to examine the extensive collection of X-rays, bones and prosected specimens always available in the dissecting room. The dissecting room is open for private study throughout the week.

You will find that the mass of information you will be expected to absorb is somewhat daunting, even though modern anatomy courses have eliminated the detail which characterised the subject in the past. However, if you make the dissecting room a focal point for your study, you should find it easier to build up a clear understanding of the three-dimensional relationships of structures within the body.

At the end of the second year, you have the opportunity to study for an Honours BSc. Currently the Division of Anatomy and Cell Biology offers courses in Developmental Neurobiology; the Biology of Connective Tissue; Forensic and Archaeological Osteology.

Professor M Berry

Biochemistry

The Biochemistry part of the BMS course is taught over five terms. We have the clear aim of providing a firm foundation in biochemistry and molecular biology which is necessary to keep pace with the exciting and very rapid advances in modern medicine. In the first year we cover the whole range of mammalian biochemistry, we try to teach the principles and hope that students will develop

an understanding of the ways that the different metabolic systems interact. This is not easy—it requires a fair bit of work from the very beginning but the understanding that comes at the end of it all can be very satisfying! The second year program is quite different. Now the basic biochemical understanding is assumed and this is used to explore biochemical aspects of a wide range of topics that are of special medical importance. For example, in the first year the basic ideas of DNA and molecular genetics are discussed, in the second year this information is used to explore in much more detail the medical applications of the new Molecular Biology. Armed with this information it is then possible to spend some time on the recent biochemical advances in the understanding of the causes of cancer. As an example on the metabolic side, we hope that second year students remember some of the basics of metabolic control from the first year—this can be applied in the second year to explaining some of the metabolic problems that arise from spending too much time in the bar.

A variety of teaching methods are used in both parts of the course. The backbone of the course is the lectures. These effectively define the syllabus and cover the course very completely—although it is always a good idea to read around the subject. These are backed up by regular tutorials—in the first year with one tutor who therefore gets to know a small group of students very well. In the second year, students rotate among tutors for the particular topics. The other type of small group teaching used in both years are the practical classes. These are important for several reasons. Firstly, biochemistry is an experimental subject—many aspects are made more easy to understand by doing it oneself. As well as this, carrying out a certain amount of laboratory work in areas related to the clinical tests that doctors request from the clinical chemistry laboratories gives some feeling of the reliability of them and some of the problems of interpretation. Thirdly, it is important to develop the habits of making an accurate record of observations. Not the least useful aspect of the practical classes is that they give an opportunity for staff and students to discuss biochemical problems in a relatively informal way.

One final point is that all the staff in the Division of Biochemistry hope that any student that has a problem with the subject will come and talk about it. Solving a small problem early on can make a big difference as the course proceeds.

Professor A T Diplock

Pharmacology

Medical pharmacology is the science of chemicals (drugs) that are used in the prevention, diagnosis, and treatment of disease. The interactions of drugs with the body are divided into two classes: pharmacodynamics, the effects of the drug

on the body, and pharmacokinetics, the way the body affects the drug with time. Pharmokinetics involves the absorption, distribution, metabolism and excretion of drugs. These topics are introduced in the first year but more detailed study is left until the student's clinical years. Emphasis in the preclinical course is placed on the mechanisms of action of drugs. In the first preclinical year, students are given a lecture course which starts with general pharmacological principles and is followed by lectures on the effects of drugs on the body systems, including the autonomic nervous system, neuromuscular transmission, respiratory system, cardiovascular system, kidney, and gastrointestinal system. In the second year, lectures are given on drugs affecting the central nervous system and the endocrine system. In addition, important topics such as drug misuse and dependence are discussed.

Tutorials are given throughout the five terms of the pharmacology course and students will take part in six practical classes which are held in the first preclinical year. The practicals are an important part of the course and are compulsory. They are carried out by students on themselves and involve studies of some important (but innocuous) drugs on the human body.

In summary, the object of the preclinical pharmacology course is to provide the student with a thorough knowledge of how drugs work and an introduction to the effects of drugs on the major body systems and their uses in clinical medicine.

Professor M Neal

Physiology

Physiology is the study of body function, and tries to answer the question—'how does the body work?' It is therefore very much a living subject studied at all levels of biological organisation from sub-cellular organelles, through organs and functional systems, to the whole organism, including man. All members of the Sherrington School of Physiology are actively researching into aspects of the subject and we are all great enthusiasts both for our specialised areas and for the discipline as a whole. We try to impart this enthusiasm and excitement to students in our teaching, and you must forgive us if occasionally we show our disappointment when students do not reciprocate.

Physiology is a subject for understanding, not one for learning by rote. Such understanding only comes when a few basic facts have been assimilated, but our teaching aims to keep these to a minimum whilst maximising the student's understanding. We aim to make lectures interesting, and perhaps even provocative, leaving you to glean the basic facts from text-books. A common cause of examination failure is a slavish learning of facts without the necessary broad reading that gives a broader appreciation of overall function.

The Sherrington School which is on the St Thomas's Campus, was formed by the amalgamation of the Guy's and St Thomas's departments in 1989. Students spend one complete day each week studying Physiology. A typical day has two lectures and a tutorial in the morning with a practical class in the afternoon. Most of our practicals are studies on yourselves. They give you an early opportunity to develop important clinical skills such as taking blood pressure and examining the pulse. Later classes involve study of such diverse effects as water loading, exercise and rotation in the body. Separate courses are run for Dental and Medical students. The Dental course runs over three terms with further study in the second year Oral Biology Course; the Medical course extends throughout the first five terms of the preclinical period.

Each year a group of more able and enthusiastic students spend their third year studying for an intercalated BSc in physiology, when they have the opportunity to study in depth some aspects of the subject which particularly interest them. An important component of this year is the research project which is carried out under the supervision of a member of staff. The quality of work achieved in these projects is now so high, that the students are able to communicate the results at a meeting of the Physiological Society and many are able to publish their first paper in a quality journal.

We look forward to welcoming you into the Department.

Dr F J Imms

The clinical course

Throughout most of the first year, there will be a weekly Clinical Demonstration, given by one of the clinicians, often in collaboration with the pre-clinical staff. The clinical conditions covered at these Demonstrations are generally relevant to the pre-clinical topics being taught at the time. They will aim to show the clinical relevance of the basic science and show how knowledge of basic science is important in clinical medicine.

In the second year of the pre-clinical course, more individual patient contact is developed. In the fourth term, all students will have two sessions with GP practices, and make some home visits to patients. There will also be some sessions with patients on the wards, followed by feedback with clinicians. These contacts will help students to realise what it is like to be a patient in general practice or in hospital, and introduce some aspects of communication skills. These skills are developed further in the fifth and sixth terms, when there is more formal teaching on how to take a history and to perform a clinical examination. The object of this course will be to prepare students to start their clinical training on the wards.

P J Rees

Recent Advances In The Field Of Allergy

A short account of current reserach

As in other areas of medicine developments in the field of allergy have arisen both from basic science and from clinical studies. The application of basic science, particularly of modern techniques in cell and molecular biology, has led to a greater understanding of the basic mechanisms of allergy, whilst clinical studies continue to teach us about the management of allergic disease.

The development of atopy

The familial nature of atopy has been recognised for many years. Studies from Oxford have suggested that atopy has an autosomal dominant mode of inheritance and that the gene for atopy is located on chromosome 11q. Cookson *et al* studied 239 members of 40 nuclear and 3 extended families. 90% of the atopic children in the nuclear families had at least one atopic parent, and in the 3 extended families 31 of 47 (66%) offspring of marriages between atopic and unaffected parents were atopic. They concluded that atopy, as defined as a propensity to produce IgE in response to common allergens, is inherited as an autosomal dominant character and that its clinical expression is dependent upon interaction with other factors. This work was extended by studying linkage between atopy and a number of chromosomal markers. None of the first sixteen markers studies showed any linkage with atopy. However, a marker for a region on the long arm of chromosome 11 was found to be linked with the inheritance of atopy in 7 extended families. These findings have yet to be confirmed by other centres. The authors pointed out that there may be other modes of inheritance of atopy, and that genetic factors may interact with environmental factors to determine whether an individual develops specific IgE to common allergens, and whether such immunological responses are associated with disease. However they raise the exciting possibility that a gene responsible for atopy may be characterised, with obvious implications for our understanding of allergic disease, and possible therapeutic implications.

With regard to environmental factors, a study by Sporik *et al* suggests that exposure to house dust mite allergens in early infancy influences the development of asthma in childhood. Children at risk of developing asthma or atopic disease were identified by selecting parents, one of whom had hay fever or

asthma. The level of the house dust mite allergen, Der p 1, was measured in the homes of 67 children at 1 year of age and at follow up at the age of 11 years. The development of asthma and atopy to house dust mite was monitored in these individuals. Of the 17 children who had asthma at age 11, 16 were atopic with specific IgE to Der p 1. There was a trend to increasing degree of sensitisation at the age of 11 with increasing exposure to Der p 1 at 1 year of age, and all but one of the children with asthma at age 11 had been exposed to more than 10 μg of Der p 1 per gram of dust in infancy. Of the three children exposed to less than 2 μg of Der p 1 per gram of dust in infancy none developed asthma in childhood. There was a correlation between early exposure and current wheezing. This study raises the important possibility that the development of asthma in childhood may be lessened by reducing exposure to common environmental allergens.

With regard to the molecular mechanisms of IgE regulation, it has been shown that interleukin (IL) 4 is able to switch on IgE production by B lymphocytes. Conversely, interferon-gamma (IFN-γ) has the ability to switch off IgE production. Although such studies of molecular mechanisms may seem rather removed from clinical practice it is hoped that they will eventually lead to advances in our ability to regulate IgE production and hence our treatment of allergic disease.

Immunotherapy

Following several deaths from hyposensitisation, the Committee on Safety of Medicines issued strict guidelines in October 1986. It was recommended that such treatment should only be given where full cardiorespiratory resuscitation facilities were available, and that the patient should be observed for 2 hours after each injection. Inevitably this led to a virtual cessation of immunotherapy in this country. A recent report of a controlled trial of immunotherapy in summer hay fever is therefore of interest. Forty individuals were recruited of whom 37 completed the study. There was a highly significant reduction in symptoms and drug use in patients who received immunotherapy compared with those who received placebo. Of 523 active injections in 19 subjects, there was one systemic reaction 10 minutes after injection, which was readily treated with adrenaline. There was one delayed urticarial reaction ½ hours after injection.

This present study confirms other studies which show that immunotherapy is effective and safe in subjects with hayfever. This careful selection of subjects undoubtedly contributed to the successful outcome of the study. The authors were careful to stress the importance of patient selection and the need for administration by trained persons under medical supervision with immediate access to full resuscitative facilities.

Immunotherapy has been shown to be of benefit in a number of clinical settings, such as in venom allergy, and continues to be used widely in North America and the rest of Europe. In our own department, and a few other centres, it is used successfully in the management of patients with anaphylaxis to stinging insects. There is no doubt that the previous problems in the UK were due to poor patient selection and administration by inadequately trained persons with inadequate facilities. As and when immunotherapy becomes more widely available again in this country it will be essential to ensure that it is administered to carefully selected patients, by trained individuals with adequate facilities.

Asthma

Asthma is characterised clinically by episodic reversible bronchospasm. This is associated with an exaggerated bronchoconstrictor response to a wide range of pharmacological and irritant stimuli, termed airways hyperresponsiveness, and the presence of airways inflammation. The degree of airways hyperresponsiveness correlates with the severity of asthma as assessed by a number of clinical parameters including the presence of symptoms, the requirement for medication, the extent of reversible airways obstruction and the diurnal variation in peak expiraory flow rate.

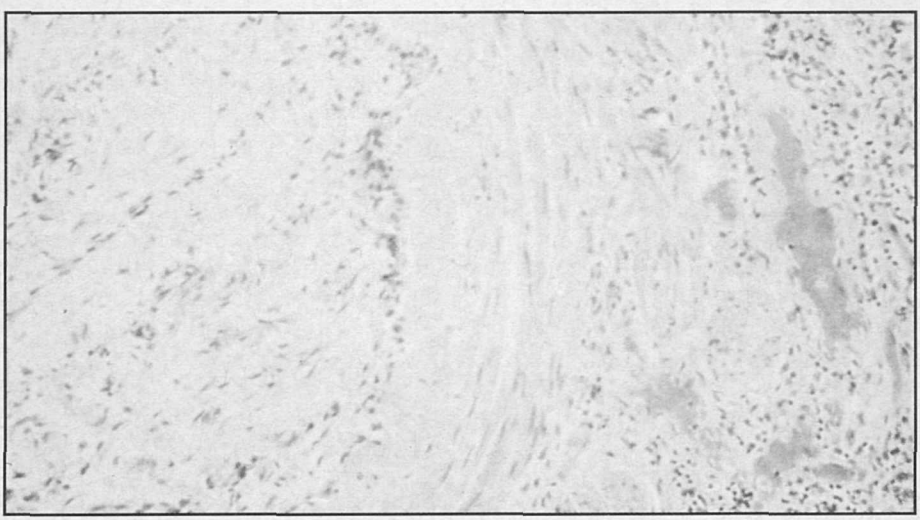

Figure 1 Pathological changes in the airways in acute severe asthma

Early studies in patients dying from acute severe asthma revealed marked inflammation of the bronchial tree. There was plugging of the lumen with mucus, epithelial cells and eosinophils; shedding of the epithelium; basement membrane thickening; smooth muscle hypertrophy; and an intense inflammatory cell infiltrate in the mucosa and submucosa characterised by a predominantly eosinophilic infiltrate, but also containing mononuclear cells and neutrophils. The use of fibreoptic bronchoscopy has enabled bronchial biopsies to be obtained from subjects with asthma in life. These studies have confirmed that a similar pattern of airway inflammation is present in subjects with mild to moderately severe asthma, in particular showing the presence of activated eosinophils and T lymphocytes, and of immature monocytes in the airways of asthmatic individuals. Several markers of the severity of inflammation in the airways correlate with the severity of asthma.

The development and maintenance of the inflammatory response in asthma is likely to be a consequence of a complicated interaction between various cells and the mediators they generate. In this regard the characterisation of an ever-increasing number of cytokines and of molecules mediating recruitment of leukocytes to an inflammatory focus is of interest. It is anticipated that considerable advances in our understanding of the mechanisms of inflammation in asthma will be achived in the next decade with corresponding therapeutic advances, perhaps through the development of drugs targeted to specific cytokines, or those molecules that are involved in the recruitment of leukocytes into the airways.

Treatment of asthma

A recent contribution to the management of asthma both in general practice and in the hospital setting was the development of guidelines for the management of asthma in adults (British Thoracic Society, Royal College of Physicians of London, King's Fund Centre, National Asthma Campaign). This arose from a concern that morbidity and mortality from asthma are unacceptably high in Britain and that the under-diagnosis and under-treatment of asthma contributes significantly to both morbidity and mortality. Given the possible central role of inflammation in the pathophysiology of asthma, it is important to emphasise the value of prophylactic anti-inflammatory treatment. For the majority of asthmatic individuals inhaled low-dose corticosteroids are very effective and very safe. In addition, the regular administration of diosodium cromoglycate has also been shown to be of benefit. Beta-2 agonists are best used for the treatment of acute episodes of bronchoconstriction. There is concern that regular use of long acting beta-2 agonists may actually increase the severity of the underlying disease, whilst masking symptoms. This remains a controversial area, but it is my opinion

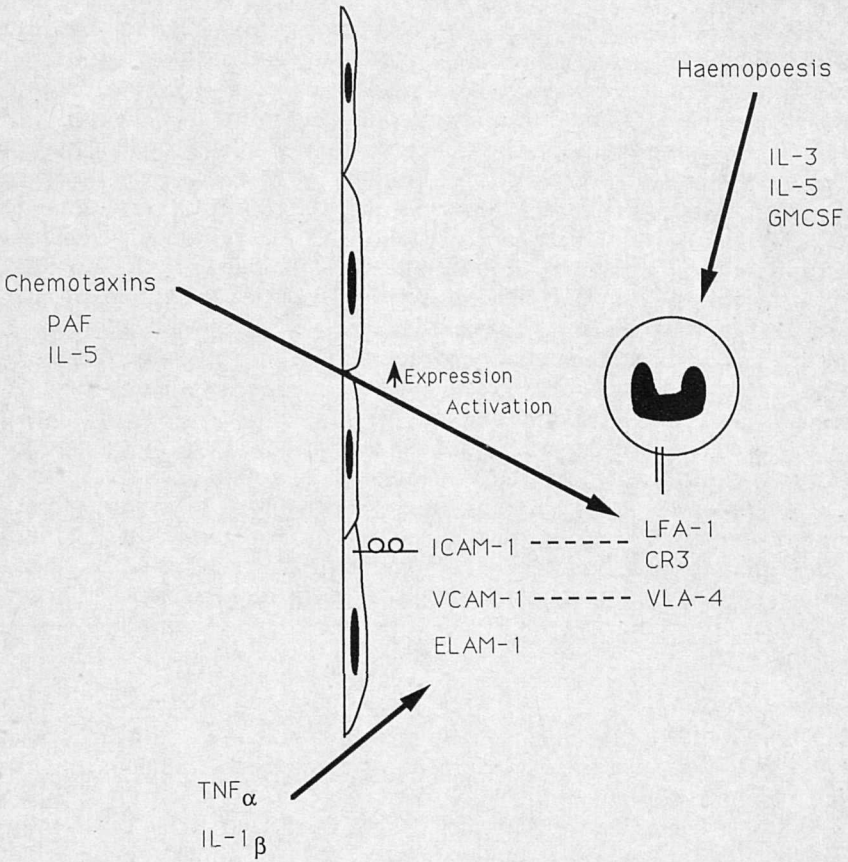

Figure 2 Putative rôle of cytokines in the recruitment of eosinophils to the site of allergic inflammation

that beta-2 agonists should be used for symptomatic treatment of bronchospasm, and that patients should only be treated with regular long acting beta-2 agonists in combination with regular anti-inflammatory treatment.

Future developments

This review has highlighted just some of the recent developments in the field of allergy. Further advances in our understanding of the regulation of IgE, the nature of atopy, and the mechanisms underlying inflammation of the airways in asthma can be expected in the next few years. One would anticipate that these will in turn lead to advances in our treatment of allergic disease.

Dr Jonathan P Arm
Lecturer in Medicine
Dept of Allergy
Guy's Hospital

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The Myth of Harley Street

'Nothing is Truer than a Myth.' Eric Strauss

Perhaps, out of interest or from necessity, you have had occasion to visit the Inns of Court in London. Whether or not your life has included this experience, the Inns themselves represent a classical example of a centre of excellence in a profession.

Occupying two contiguous rectangles overlapping the City of London to the East and the City of Westminster to the West, their Northern Limits Holborn and their southern the Thames Embankment, they are transected by the Strand and Fleet Street running from the Law Courts south of Chancery Lane, eastwards to their South Eastern boundary of Bouverie Temple Avenue.

Architecturally they are a melange of Tudor and Gothic, a maze of lawns and lanes, and an embodiment of quiet dignity and the mysterious human investion of law and order. They stand peacefully untroubled by the clamorous traffic which surrounds them; traffic which, unlike Oxford or Cambridge, they have succeeded in maintaining subdued within their precincts. I would like to believe that they will always stand like this, an island of England, a City within a City, inperturbably serene.

My father was an eminent solicitor, and I grew up among lawyers, barristers, and the occasional judge. The Law, seen through a child's eyes, is neither awesome nor an ass. It is human, fallible, and sometimes pompous. Unlike medicine, which is an art and science of natural life, the law is indeed a man made invention, whose ideal is the superb but artificial concept of absolute and impartial justice. Like most ideals, this is rarely completely possible in practice; but lawyers accept this as a fact of life. Where they guard their precepts and their practice most closely is in the actual organization of their profession; and the rules binding the use of Chambers of the Inns of Court are one rigorous example.

You can find good and bad lawyers in the Inns of Court: but nowhere therein can you find a practising man or a woman who is not a Member of Bench, Bar, or the Law Society. Quacks (unqualified practitioners) are not only unknown in the Inns of Court: they can be prosecuted by law for pretending to be qualified or competent, wherever they may be. The Law takes good care of its own.

No such protection for the profession or the public exists in medicine. The most deservedly eminent physicians and surgeons in the land, if they still choose to do part of their work in the Harley Street area, must daily rub shoulders with

charlatans and mountebanks with no medical qualifications whatsoever.

Provided you can find a vacant room and pay the rent, you can set up in Harley Street or Wimpole Street, Queen Anne Street, Weymouth Street, or Devonshire Place, tomorrow. All you must avoid is calling yourself a Registered Medical Practitioner (if you are not), prescribing certain scheduled drugs, and signing death certificates.

So long as you observe those simple precautions you can put up your plate as chiropractor, naturopath, sexologist, or even psychotherapist, and no one can say you nay. Between fifteen and twenty per cent of your neighbours will anyway have done just that. So, while eminence cannot enhance the address, deception can and does debase it.

Yet daily in the Law Courts or in the Press we hear or read quoted the opinions of 'Harley Street Specialists' as if the address itself counted for something. It counts for nothing: or as much and as little as Camden Town, Bethnal Green, Belsize Park or Western Avenue.

Having thus scattered the real professional significance of the address, with sincere impartiality, over some random samples of the Greater London area (and we might equally justly have substituted Carnaby Street or The Old Kent Road), perhaps we owe it to Harley Street and its *environs* to attempt to define their actual locale, as precisely as we did those of the Inns of Court.

The Harley Street area, whatever its significance or lack of it, certainly permits comparably firm geographical definition. It is an almost square rectangular area of the West End of London, North of Oxford Street, and bounded on the South by Wigmore Street, on the North by the Marylebone Road, on the East by Portland Place, and the West (generously) by Baker Street. Since all these boundaries, as measured on *The Geographer's Master Atlas of Greater London*, are roughly one half mile long, the area they enclose is very close to one quarter of a square mile. Herein is concentrated that myth of exclusive professional excellence, whose fame drifts mysteriously on, without any continuing justification except habit and a remarkably tenuous if persistent tradition. More remarkable still, the area has assumed these exclusive qualities over the last century, without ever having seriously attempted to deserve or achieve them.

So just what is the myth of Harley Street? It is quite simply that anyone purporting to heal the sick, within this magical quarter of a square mile, is at least likely to be a doctor or dentist of unparalled excellence, at the acknowledged peak of his profession, and one of the best practitioners of his subject in the world.

So much for the myth; still, as I have said, sedulously propagated and quite possibly sincerely believed by the majority of lawyers and journalists of Britain. The Medical Profession themselves know better, but most of them keep quiet about it. Why? Perhaps first most of all because each one of us knows a number

of excellent colleagues, deservedly eminent in our profession and comparably esteemed, who still have 'rooms in Harley Street' (or Wimpole Street, or Welbeck Street, or Devonshire place . . .); and we have no wish to appear to be attacking them. Nevertheless, the number and proportion of these admirable professionals has been declining for years: and even their presence does nothing to justify the pretentious pretences of the address. Many of their colleagues of comparable excellence, practice exclusively from their hospitals, with all these hospitals' facilities, professional contacts, nursing and ancillary skills, and students, junior and senior colleagues, and clinical laboratory and technological resources immediately at hand. Those are where the real centres of excellence are to be found: and those are even more exclusive to such aspirations to excellence than the Inns of Court.

But Harley Street is in no danger of fading from the scene from lack of candidates for the address; seekers of the real gold despite the tarnished glitter and totally non-existent integrity of the area as such. Vacancies are still snapped up, new clinics open, and not all the newcomers are charlatans. Not all, but certainly many.

Those who are not, include a handful of general practitioners who, impatient of private practice facilities for them under the National Health Service (which provides far better opportunities for its hospital consultants to use but not abuse), set up model private general practice schemes, with inpatient as well as outpatient services, on their own initiative. For them, the Harley Street area is the lodestone of private enterprise. But this magnet draws in many more men and women who are interested primarily in the exploitation of the bogus mystique, the non-existent exclusiveness, and the totally false mantle of authenticity still ascribed to the address by the rest of the world. And this indeed still retains much of its hold on popular imagination; more perhaps in its own way than even Carnaby Street and the Kings Road Chelsea have achieved for themselves, by far more obvious effort, in the role of purveyors of gear.

Visiting celebrities have risked or suffered mutilation, international stars and statesmen have sacrificed their money, their health, and sometimes their lives, before this altar where even the nursing homes have no resident medical staff and no cohesive team of permanent and probationer nurses. There are thousands of people offering their skills and wares in the Harley Street area. Not more than about two thirds of them may be on the Medical Register at all. Of those who are, at least fifteen to twenty per cent may be doctors whose main work lies elsewhere, who hold no registrable qualification for the speciality they profess while there, and who may include respectable suburban general practitioners and even medical officers of health on their days or half days off. I am not blaming them for jumping on to a creaking old bandwaggon. It is the roadworthiness of the waggon itself which I venture to question.

When I first became a Consultant by appointment to Guy's Hospital, I myself took a room in Wimpole Street, as was then the custom. I gave it up after about eighteen months, but I had had time to learn a good deal about the ethology of that particular human jungle, and I have kept in touch with it ever since.

Among my fellow occupants of our rented house in Wimpole Street were a hypnotist who turned out not to be medically registered, a fashionable abortionist, and an extremely capable dental surgeon with a flair for gimmicks and colour photography: he kept a beautiful collection of tropical fish in an aquarium in his own private waiting room. Part of the secret of his personal success was his readiness to undertake dental work under intravenous anaesthesia, with himself as anaesthetist as well as operator. This was always a hazardous procedure, and has since been declared illegal. I departed from this colourful scene, not at the time from any ethical scruples, but because the journey to the West End was wasteful and time consuming, and the isolation from standards of professional excellence in my own work, as well as the lack of proper facilities for its thorough performance, were proving avoidable frustrations. Car parking remained a perennial problem.

Needless to say, my departure made no difference whatsoever to the continuing Harley Street boom. Some twenty years later, when an outstanding colleague from Guy's (a gynaecologist and obstetrician) was conducting some research into abortion, he discovered that 40% of all registered abortions in the United Kingdom since 1967, had been performed privately in that square quarter of a mile under discussion. The 1967 Act made abortion legal under certain specified conditions, and required that all such procedures be registered at the time and place they were undertaken, by those responsible. Not very long after this another doctor was alleged in the press to have offered for sale, as a going concern, a private abortion clinic in the area for a sum in the region of a million pounds: he was also alleged to have assured potential investors of a profit on this investment within a year or two. His name is no longer on the Register.

These are simply instances of the business potential of the myth and its exploitation. Clearly this is not an instance of bad money driving out good: here both base and noble coexist in equally bizarre congruity. How did it all originate? A hundred years ago, the Harley Street area was a fashionable residential area for wealthy Londoners, rather like Mayfair, Kensington, Chelsea, and Hampstead have since become. The Barretts resided in Wimpole Street for convenience, not professional advancement. Now the area swarms with hustlers, side by side with the rearguard of the old brigade. Now it has earned the name of The Golden Fleece.

But perhaps that is a harsh and superficial judgement on a phenomenon deserving more balanced and delicately perceptive assessment. After all, what

really keeps Harley Street and company going, is the eternal desire of mankind for magic—at a price. Powerful magic must also be Respectable—otherwise it may become uncontrollable and therefore threatening—even terrifying.

Harley Street clings determinedly to the mask of respectability even though the magic has long departed. When the London Borough of Marylebone sought to increase rates in the area (a tiny fragment of its total responsibilities), no lesser gentleman than the Secretary of the British Medical Association succeeded in getting a question asked in Parliament about the potential folly of thus striking at the foundations of the *crème de la crème* of British Medicine (the words here are my own—the implication is all I now remember).

There are indeed centres of excellence in British medicine and surgery which are the equal in clinical skill of anything in the world. But they are not in Harley Street. Behind its mask, the area can be perceived to be performing a rather different function, at least as ancient and no less traditional. A clue to its nature is provided by the following quotation: *'Hamare ghali ayeh, achha din . . .'*

Freely translated from the Hindustani, this means 'This is our street, please come, good day to you'—and was the traditional chant of harlots inviting passers by in the days of the British Raj in India.

DS-C

Dental Anaesthesia

Fifty years of practice

I entered practice in January, 1936, at a time when cocaine-based local anaesthetics were on the way out, although a lot of older practitioners still used them. While cocaine had some undesirable toxic and addictive properties, there is absolutely no doubt that its introduction in 1885 was one of the biggest breaks-throughs in making dentistry more comfortable, or more tolerable, for the patient. The successor to cocaine was novocaine, marketed by the Saccharin Corporation. I was never very happy with this; it was a much weaker anaesthetic than cocaine, and there was a distinct tendency to after-pain, a dull ache lasting for a few hours. In the very earliest days we used to brew this up with saline solution in little porcelain cups; very quickly the well-known glass cartridges were introduced by Messrs Waite, still in use by the hundred thousand. Many years later lignocaine, a much better product, was introduced. I was much happier with this.

The straight gas (nitrous oxide) was the only form of general anaesthetic that many doctors would administer. There would be a large bag connected to a face piece by a three-way valve, the three ways being: Air, Gas to and fro; Rebreathing. When the desired degree of anaesthesia was reached, the face piece was removed and the dentist whipped out the required teeth in the very short time available before recovery. Many dentists became adept at extracting with lightning speed, although one did not know how many broken roots were left in for later removal. More enlightened practitioners might give gas from a nosepiece, lifting this off for perhaps every fourth breath. This was the earliest attempt at reducing oxygen lack. My preferred anaesthetist before the war owned a nice little gas and oxygen machine produced by the McKeeson Company. This eliminated oxygen lack and enabled much longer and unhurried operating to take place. A little later, British Oxygen produced their range of Walton gas and oxygen machines; very satisfactory, although the percentage of oxygen might be a little vague. After all, one does study the patient rather than the dials. There was also ethyl chloride, fine for children but not to be prolonged. I also recall vinesthene, inhalation of which was described to me as like red-hot fishhooks going down the trachea. Any child given this would regard the dentist with fear and loathing for years afterwards. Unsurprisingly, this compound rapidly went out of use.

In the mid-century many single-handed practitioners, myself included, combined the roles of operator and anaesthetist in emergency. This was a useful, humanitarian, and much appreciated service for suitable cases; never-

theless pressure began to build up to denigrate or obstruct this procedure, ostensibly to ensure the patient's safety, although I always felt that financial considerations and professional jealousy played a part. I objected violently to this ill-informed propaganda and expressed my views forthrightly to the Ministry, receiving a somewhat rambling and bureaucratic reply to the effect that while deprecating the dual function, they supposed that in extreme emergency and if there was absolutely no alternative, the operation might be tolerated occasionally.

Consider a girl who arrives with a roaring abscess. She is in great pain. You assess the position carefully. If suitable, she receives a whiff of gas. The offending molar is removed. In a quarter of an hour she departs rejoicing, free from pain, and very likely goes back to school in the afternoon.

Now consider another girl who arrives with a roaring abscess. It's Saturday morning. The anaesthetist will not operate, and *vice versa*. You telephone the local practitioners. The first half dozen are out on the golf links; the next and last is much too busy to come out. The patient received penicillin and/or paracetamol and departs, still in great pain. No luck on Sunday, you start the routine again on Monday. At the third attempt a doctor is found who can come out; you are not terribly happy with his technique and would much rather have employed someone else, but have to make the best of it. In any case, if extracting I always paid careful attention to the anaesthetic, and have in fact occasionally cut short the operation if I was not too keen on the anaesthetist's technique. Under present regulations the operator-anaesthetist can no longer function, although this matters less as the majority of present day practices are multiple. I have however known the odd multiple practice where none of the dentists felt capable of giving a general anaesthetic. Life was simpler 30, 40, 50 years ago, although I am certain that our dedication to our patients' welfare was just as great, then as now.

Maybe a slight hankering after times past is a sign of old age?

E C Hammond

Life As a Junior Surgical Dresser

A student in the '60's

It took me quite a while to realise the difference between Front Surgery and Back Surgery. More confusing, perhaps, was the fact that they appeared to be situated at either end of a corridor at the base of New Guy's House and seemed more sideways to me than 'back' or 'front'. The firm on 'take-in' had to attend Back Surgery and deal with the dressings as they arrived. It was my first taste of out-patients in the raw—as it were—and the feeling of incompetence was upon me every time I attended for a spell of duty. It was the Senior Dressers who saved our bacon when it looked as though we were about to do something truly crass. Over three months, though, it became clear that even varicose ulcers tended to heal; not to mention all the stitches we removed and the wounds of varying shapes and sizes we must have dressed.

I was on Mr Beard's Firm, and, on the whole, I think I got off quite lightly on my first surgical appointment. Mr Randolph Beard MChir, FRCS—known universally as 'Randy'—was as benign a teacher as I could have wished for. I had heard stories about the capacity of the consultant surgeon to humiliate cretinous medical students and it was a relief to see that Randy Beard was not one of them. In the sixties he appeared tall and handsome; dashing in a middle-aged sort of way with a fine head of dark hair that seemed to be held in place by some secret solution. He had very mobile expressive eyebrows which came into their own when he was duly gowned and scrubbed, and his eyes had the capacity to 'flash' whenever he particularly wanted to drive a point home. These qualities came into play in Theatres when he was operating. He was a slick a surgeon as I ever did see and some of us would time him on our watches as he commenced a cholecystectomy to the time the gall-bladder landed in the kidney dish with the clank of its accompanying forceps some seven minutes later. As often as not he would say: 'There are some surgeons who take three hours to do that operation!'

Cimetidine hadn't arrived yet and those were the days of the gastric surgeon. Norman Tanner was alive and well and regarded as the doyen of gastric surgery. It was he, by the way, who put the 'slide' into the Bassini repair. We needed to know about Billroth I and II and there were complex words that began with the prefix 'choledoco...'.

Twice I was present when a carcinoma of the head of the pancreas was successfully excised and all the connections successfully restored. Mr Beard always called this 'Tiger Country' and the term has stayed in my vocabulary. Three hours swinging on the end of a liver retractor was one thing, but when it was followed by a two hour wait on a freezing London Bridge station for the train back then the fascination of surgery adopted a whole new perspective especially when there were subzero temperatures out there.

I cannot complete this memo without a mention of Sister Calladine who reigned on the surgical ward on the third floor opposite Cornelius. She, it was, who had ward prayers at 9 a.m. every day. Dressers could quite easily be hoiked into these services as a result of taking bloods too slowly or just plain bad management. In retrospect, I think Sister Calladine was years ahead of her time.

And then there was the Saturday night take-in supper. We had a budget of ten quid to feed twenty five mouths. Our offering was a hotch-potch of roast chicken, mashed spuds and peas. The gravy was a strange business but it worked. This feast took place on the second floor of New Guy's House. The second course was always tinned fruit salad. If the Rugby Firsts had had an away fixture we tended to get invaded by them soon after ten o'clock. Once that great hairy crowd of lads arrived it was no longer safe to strike matches. They liked the freshly cooked omelette and it was a problem as to how we could get eggs off the wards without being seen by Sister Rix. In the three years I stalked the wards I never got caught although there were plenty of very near misses, but this only added to the flavour of the omelette we eventually cooked—usually with twenty or more eggs.

As a Surgical Dresser we soon noticed that all our patients tended to get better and those somewhat depressing trips to the Mortuary stopped.

Our senior registrar was Stan Cook MS, FRCS. He was very tall indeed, some six foot six of him with a quiet reassuring voice which could quite easily send a chap to sleep on those interminable ward rounds. It was here that one of my stock answers to every question was developed.

'Ten percent saline, sir.' was not a classic answer but it made a pleasant change from my usual answer which was a pause followed by a 'I don't know, sir.'

New Guy's House had a Lampsen (*sic*) Tube System. Where the tubes went is still a mystery to me but it was in operation when I first went on the wards as a dresser. Originally it must have seemed an excellent idea: a way of getting pathological specimens from one part of the hospital to another at the greatest possible speed. There must have been a few accidents, though, because blood and excrement samples, when subjected to a high deceleration will burst out of their containers and this may have been what happened when they reached their destination. Maybe there is someone who could tell me what the tube system was all about in New Guy's House.

Mr Beard's HS was R H S (Bob) Lane. He, too, was the model of politeness and showed us all what could be achieved by quiet diligence. He can't have got a lot of sleep but he was always very decent to us dressers.

When I look back, it was the conduct of the House Doctors—more than anything—that set the role-model in action. Though the houseman's lot may not have become a very happy one due to these so-called long hours they all work; it is my contention that the proper ability to manage one's superiors and to administrate effectively are two qualities which make for the best kind of houseperson.

A look at my *Medical Directory* tells me that Bob Lane got his Fellowship at lightening speed and topped it with the MS in due course. In the light of the teaching and the pleasant environment, he couldn't have had a better start on the House. As Dressers, we may have been as thick as two short planks, but it was as happy a time as I can remember. for the first time in my training, I was given the feeling that I may have made some kind of contribution to others by actively participating in their treatment and subsequent recovery.

J H Pitt-Payne

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The Brooklands Guy's Gala Meeting, 1932

The Good Old Days

After exhuming my dusty motoring tomes from my ill-used bookcase, a few fragments of history have sprung from the yellowed parchments of antiquity regarding an event held at the Brooklands Motor Racing Circuit in aid of Guy's Hospital.

This meeting, so the faded copper-plate goes, was organised by the Junior Car Club in order to benefit the funds of our noble Hospital. The programme of events was scheduled to include a *Concours d'Elegance*, followed by a parade of the competitors' cars down the finishing straight, a visit by a *Graf Zeppelin*, a green-clad *Tzigane* orchestra playing Hungarian music, and society debutantes selling programmes. Their Royal Highnesses The Duke and Duchess of York graced Brooklands with their presence; there was a skilled driving test and an aerobatics display, and the fashions in the Paddock rivalled those seen at Ascot and Goodwood.

In the morning, medical students indulged in a one-lap race won by a Mr. Lees in his supercharged Lea Francis. The pre-noon antics culminated in a race for London taxis, won by London's oldest taxi-driver, who naturally had to be photographed shaking hands with Sir Henry (Tim) Birkin! During the luncheon recess, the cars entered for the *Concours d'Elegance* were judged, these ranging from a white 1922 Morris Cowley to fine examples of Delage, 8 litre Bentley and Rolls-Royce.

Soon after the first race, the Guy's Gala Short Handicap, their Royal Highnesses arrived and took their seats in the Paddock grandstand to watch the second event. They were certainly treated to a magnificent race when Sir Henry Birkin set up the fastest average lap of the year at 124.33 m.p.h. in his single-seater supercharged 4½ litre Bentley. During the event, Birkin equalled his previous lap-record of 137.96 m.p.h. which had given him the Class C Outer Circuit lap record.

The next race was the Duchess of York's Race for lady drivers, which was won by a Miss Eileen Ellison in her type 37 Bugatti. The major event of the day, the Duke of York's Race, was then held over six laps and was confined to cars capable of over 100 m.p.h. Tim Birkin was out again in his single-seater Bentley, but had to retire after losing a tyre tread which shot high over the heads of the

spectators. John Cobb, in his V-12 Delage, broke the Class A lap record at 133.38 m.p.h., but had to take second place to Ashby's supercharged Riley.

A short interlude followed in which Flight Lieutenant Bulman displayed some remarkable aerobatics in a Hawker Hart biplane, after which the last race, the Guy's Mountain Handicap, was contested. The meeting concluded with a parade of the *Concours* competitors down the finishing straight and the arrival, on its way to Hanworth, of the *Graf Zeppelin*, which hovered low over the Paddock for a while, one engine revving slowly, until its other engine burst into song and it cruised gracefully away . . .

T Houlding

Guy's Hospital—250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.50, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital—250 Years, Guy's Gazette, Boland House, London SE1 9RT.

Welcome

May I welcome all those Freshers and Oxbridge Students who have recently started at UMDS. I hope that you enjoyed Freshers Week and got a feeling of what it is like to belong to the two great establishments of Guy's and St. Thomas's Hospitals. Get ready for some of the best years of your life and make the most of them. I hope you will find the right balance between Studying for the many exams which you will be faced with and continuing to take part in the social events and various clubs and societies UMDS has to offer.

Let me briefly remind you of the Halloween Ball to be held in November. As the main Freshers Ball it is a must, as it is brilliant fun and highly entertaining! So leave enough time to organise your balgowns and dinner jackets (we can advise you where to hire these, if necessary).

Once again have a superb term and if there are any difficulties or queries feel free to contact myself or any other member on the Students Union (we are those for you after all), or indeed any person in the years above—all of us will be delighted to help.

Gordon Kooiman

Nurses and Conflict

The summer vacation is over now, and we are all resuming our normal activities. During this break the national press usually suffers from what is known as the 'silly season'—presumably so many folk are away from the political, legal and academic scene doing things sillier than ever! This year was an exception, the press has not been short of copy, as I am sure readers are aware, and will need no enlightening about events on the world scene.

Thankfully the revolutionary changes in the former USSR have not resulted in massive loss of life and injury necessitating medical and nursing services. But this is not always the case. The Gulf War earlier this year made tremendous potential demands on the health services, reminiscent of former bellicosities.

Florence Nightingale, Elizabeth Fry, Mary Seacole, Edith Cavell, Vera Brittain and a host of others all became famous nurses owing to their connexions with the conflicts occurring during their lifetimes. Many of these conflicts arose out of war. Thus have many aspects of nursing in the past gained military connotations: the style of discipline and uniform spring to mind.

A lot of us hoped that nursing had left this arena after the major conflicts between nations earlier this century, when nurses played a significant part in patching up the wounded soldiers in battle following injuries. Of course, it is true the flow of injured has never ceased completely, and the past decade has seen the need for nurses to care for the wounded in various far-flung battlefields.

How pointless it seems in retrospect to fight all these wars causing physical and

psychological damage to the youth of each new generation as it matures. Guy's had to prepare to receive large numbers of casualties from the Gulf War, who thankfully never arrived.

As a pacifist of long standing, and a nurse of similar duration, I find all this a pitiable state of affairs. I well recall a man from, what was then called, the Ministry of Labour & National Service knocking at my door at home many years ago, waking me from daytime slumber when I was on night-duty, informing me of my invidious position as a conscientious objector from what was then compulsory service by conscript men and boys to the armed forces. My sort of action is often condemned either as cowardice, or lacking in loyalty and patriotism—but are these the real alternatives to living peacefully? When people refuse to fight surely wars will stop.

The outcome of the Gulf War could hardly be described as a victory for either side if viewed in terms of individual lives rather than nation-state priorities. There was indeed considerable re-deployment of nurses at Guy's and elsewhere which affected the civilian population.

Nurses are trained to heal—there are enough misfortunes of unexpected aetiology occurring without the need for armed conflicts to add to this. Why not a little loss of face when confronting such situations, rather than losing our heads? Fry in the 1840s, Nightingale at Scutari and the Crimea, the 'Sentence of Death' described by Vera Brittain amongst the VADs in World War One, are all images we could dispense with. Edith Cavell, alleged to have harboured aliens and helped the enemy in his hour of suffering, was shot in 1915. Her statue stands outside the National Portrait Gallery. The inscription on it carries her last words, and is a sentiment we may all share: 'I realise that patriotism is not enough. I must have no hatred or bitterness towards anyone'.

Denis Cobell

The International Congress

The 11th International Congress of the World Confederation for Physical Therapy (WCPT) was hosted by the Chartered Society of Physiotherapy (CSP) at the Barbican Centre from 28 July to 2 August 1991. This year is the 40th Anniversary of the founding of the WCPT. In the late 40's when governments and voluntary bodies were establishing international contacts to pool knowledge and experience a number of professional organisations decided to extend informal contacts which were already in existance. A meeting of Physiotherapists was convened in 1948 and a provisional committee was established. The Inaugural meeting of the new organisation, which was to be known as the WCPT, was held in Copenhagen in 1951 and the 1st International Congress was held in 1953 in London. Eleven countries were the original members and the UK was not only a founder country but the CSP provided honourary services and a material base for the first decade.

The 10th Congress was held in Sydney in 1987 and in these past 4 years the membership has increased some 20% with the present membership standing at 54 organisations of physical therapists worldwide. This 11th Congress, nearly 40 years since the last (first) in England sees the admission of 6 new member organisations which jam the existing 48 organisations reaching across the world from Australia to Zimbabwe.

The programme was diverse in depth and breadth. Each day there were 13 locations within the Barbican Centre where concurrent sessions were presented. The four main Congress Themes were Health Education, Clinical practice, Competence to Practise and Resource Management. As well as oral presentations there were specific-interest group meetings and presentations from clinical centres of excellence in the UK, audience participation sessions and poster presentations. The Congress was kindly supported by many exhibitors.

Students and teachers from the School of Physiotherapy attended as well as a dozen of the clerical staff who took it in turns to share in the experience. Other delegates came from around the world including one from the USSR, one from Romania, one from Puerto Rico and two from Venezuela the majority of the delegates were of course from Great Britain and the next largest contingent was from Australia. Students from Guy's were also part of the team of 'Yellow Jerseys' who received, directed and generally kept a smoothly running show.

The Social Programme included tours of London, Oast Houses in Kent, Oxford and the 'Heart of England'. There were Medieval feasts, special-interest suppers, a gala concert (specially laid on for the Congress) a Government Reception in Lancaster House and a Reception at the Science Museum which was attended by HM The Queen and HRH The Duke of Edinburgh.

The opening ceremony in the Barbican Hall was charged with anticipation. The stage was decorated with the flags of the 54 member states and the Congress was opened by the President of the CSP. Short addresses were given by the President of WCPT, the Chairman of the CSP, the Chairman of the Organising Committee and a Student Representative to the CSP.

From my place in the balcony and through ageing eyes I was unable to recognise the student until she took the rostrum when I was surprised and delighted to discover that it was Sasha Mayes—a Guy's Student. She made an excellent speech which was received very enthusiastically by the audience. During the reception afterwards she was inundated with congratulatory remarks and was invited to cheer up the Chelsea Pensioners who were clamouring for her attention. It was also Sasha's honour to present the bouquet to the Queen on the Monday evening reception.

And so the Guy's school was once again in the forefront of World Affairs.

The physiotherapists' of the world were invited at the closing ceremony to gather in Washington DC in 1995 for the 12th International Congress. Hopefully many Guy's trained physiotherapists will be there.

Diana Innocenti

Sports Round-up

You will probably have done some sort of athletic activity at school or college (even if it was only to put down on your UCCA form) and there is no excuse for you to stop now. If you have not, then this is an ideal opportunity for you to start.

The school owns two sets of playing fields, one at Honor Oak Park and the other at Cobham. We also have a boathouse at Chiswick and sailing amenities at Burnham. On campus there are gymnasiums, a snooker room, both squash and badminton courts together with a swimming pool and sauna. We hire special facilities we do not have e.g. the astroturf at Southwark Park for hockey training (match pitches are at Cobham and Honor Oak Park).

Most of the clubs are amalgamated, but some still maintain their own independence, e.g. Guy's Hospital Rugby Football Club which was established in 1843 and is the oldest Rugby Club in existence!

The top teams are very competitive and mostly quite successful. Last season the first and second rowing VIIIs both won their divisions at the United Hospitals head of the river with the first VIII going on to win the senior first division in the UH head of the river; the football second XI won the

UH cup for the third time in four years and the hockey first XI were top of the second division of the Morison Stoneham UH league and have been promoted to the first division.

However you do not have to be a Martina Navratilova to play tennis here or a Graham Gooch to play cricket as most clubs cater for all shapes, sizes and standards, social teams being very popular.

Christmas and Easter are a popular time for annual tours, which are usually fairly inexpensive as they are subsidised, mostly continental in nature and well organised. Some teams like to travel further afield, as was demonstrated by the Netball Club who visited Jamaica last April.

Sporting events to look out for in the very near future are the Fresher's trials (which are a must) special Fresher's fixtures, pre-season friendlies and the official start of the sporting season. So, take your pick and have an enjoyable first year's sport.

Abhi Lall

Rugby Club

Guys Hospital RFC 1st XV 13
United Services Portsmouth 18

Traditionally one of the harder fixtures in the Guy's RFC calendar, this match turned out to be a very close contest—which could easily have gone either way. Despite the defeat, this is an encouraging start to the season—considering a lack of preparation on the Guys part and the practice that the opposition had gained in the Gulf.

Despite a clearcut height, weight and strength advantage of the US Portsmouth team (except Ken Ivil), the Guys team seemed to have superior fitness and a much greater keeness to run with the ball—a tactic to which the dry conditions were suited. However dominence of mauls and most scrums by the opposition made the opportunities to use the backs sparse—but the Guys loose forwards worked excellently at the breakdowns to win the ball. Through several foolishly conceded penalties—however—the Guys side found themselves behind—not least due to USP's very lucky or very good kicker—(5 out of 6 attempts). But the hard running and at times slick passing of the Guy's back line meant that two tries were scored to USP's one—one by Alan Jones and the other by Neil Davies.

With training going well and fitness levels increasing prospects seem to be promising order the new Captain Roy Cunnington—and the side is looking forward to a confrontation with last year's UH cup losing finalists, the Royal London Hospital, on Saturday 14 September—a match that we hope may ask some questions about the seeding system employed in the UH cup competition.

Team

P Cunnington (C), M Rose, A Jones, S Lewis, J Worth, G Bevan, N Davies, J Combes, K Ivil, C P Addy, E Cheak, G Ryan, G Thomason (sub J Boothroyd), C Beardmore, W Llewellwyn (Sub J Barwell).

New Dentists

The following students qualified BDS University of London in July 1991 and are life members of the United Clubs.

AHLOWALIA, Bhajneet Singh
7 Batchwood Drive, St. Albans, Herts, AL3 5RZ

BERMAN, Mark Richard
2 Dorset Drive, Edgware, Middlesex, HA8 7NT

CARLING, Michael
45 Stainton Way, Peterlee, County Durham, SR8 2BJ

COWIE, James Charles Arthur
231 Bramhall Moor Lane, Hazel Grove, Stockport, Cheshire, SK7 5JL

DOSHI, Rahul Rohitkumar
5 Arden Close, Harrow-on-the-hill, Middlesex, HA1 3LA

GASIOROWSKI, Gregory Waclaw
20 Buxton Gardens, LONDON, W3 9LQ

HATFIELD, John Randall
8 High Street, Chipping Sodbury, Bristol, BS17 6AH

JAMIL, Muhammad Naveed
14 Lawrence Road, LONDON, SE25 5AA

JUDGE, Roy Birander
8 Buck Lane, Kingsbury, LONDON, NW9 0NH

KHAN, Madin Ullah
3 Winton Court, Winton Road, Bowdon, Altrincham, Cheshire, WA14 2PD

KINGSMILL, Virginia Jane
Quiet Court, Graffham, Petworth, West Sussex, GU28 0NZ

KUMRAI, Harish
74 Huntingdon Road, East Finchley, LONDON, N2 9DU

LIU, Chih Lon
52 Brighton Road, Salfords, Surrey, RH1 5BX

LIU, Josephina Shook Lee
11 Poynings Way, Woodside Park, LONDON, N12 7LP

MANARA, Simon
280 Worple Road, Wimbledon, LONDON, SW20 8RG

MERCER, Ian James
26 Edward Road, Great Sankey, Warrington, Cheshire, WA5 3LT

MICHAELS, Simon Clifford
"Windyridge", 13 Hartsbourne Avenue, Bushey Heath, Herts, WD2 1JP

OWEN, Sarah Beverley
"Tan-Y-Castell", 68 Merthyr Mawr Road, Bridgend, Mid Glamorgan, C31 3NR

PATEL, Bina Girish
6 Mountsfield Close, Queens Avenue, Maidstone, Kent, ME16 0EZ

PERERA, Esther Harini Kumari
30 Wadham Gardens, Greenford, Middlesex, UB6 0BP

ROWE, Carol Ann
26 Shipwright Road, Lady Dock, Rotherhithe, LONDON, SE16 1QB

SAJJANHAR, Raj Kumar
7 The Sheilings, Emerson Park, Hornchurch, Essex, RH11 2QD

THOMAS, Steven John
66 Pennard Road, Kittle, Swansea, SA3 2AA, WALES

TOMES, Nicholas Guy
"Pantiles", 7 The Heythrop, Ingatestone, Essex, CM4 9HG

WARE, Peter Ivor
139 Percy Road, Whitton, Middlesex, TW2 6JE

WILLIAMS, Leigh Campbell
64 Highfield Road, Attleborough, Nuneaton, Warwickshire, CV11 4PL

Deaths

CUTLER, E. Patrick. LDSRCS (Guy's 1934–38). He passed away suddenly on 18 September at the age of 75 in his home at Westcliff-on-Sea. Sadly missed by his wife, Peggy, his children and grandchildren.

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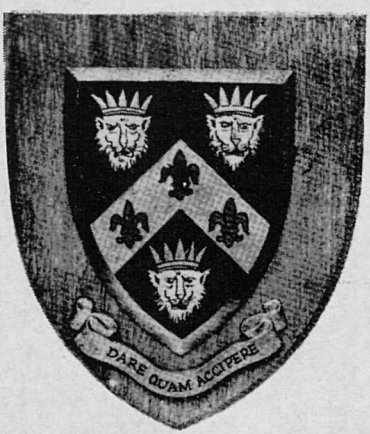

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Twenty Third Lament

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and students hopefully to shirk.

Where 'phones and queries last all day
and letters come who've lost their way
Plus moans and groans and swollen faces
Rival patients who jump their places.

The other floors don't want to know
Where all their awkward patients go
As long as good old twenty-three
Gives treatment satisfactorily.

On Fridays where do staff all go?
To tournaments or some such show
To golf and boost their handicaps
And leave their patients in our laps.

Oh for some god-fairy mother
Or fair minded union brother
That we might leave on dot of five
Feeling reasonably alive.

That we might join in all the fun
and feel the week-end's just begun
On Friday, spot on mid-day,
Could we go home and start to play?

Doreen Clare

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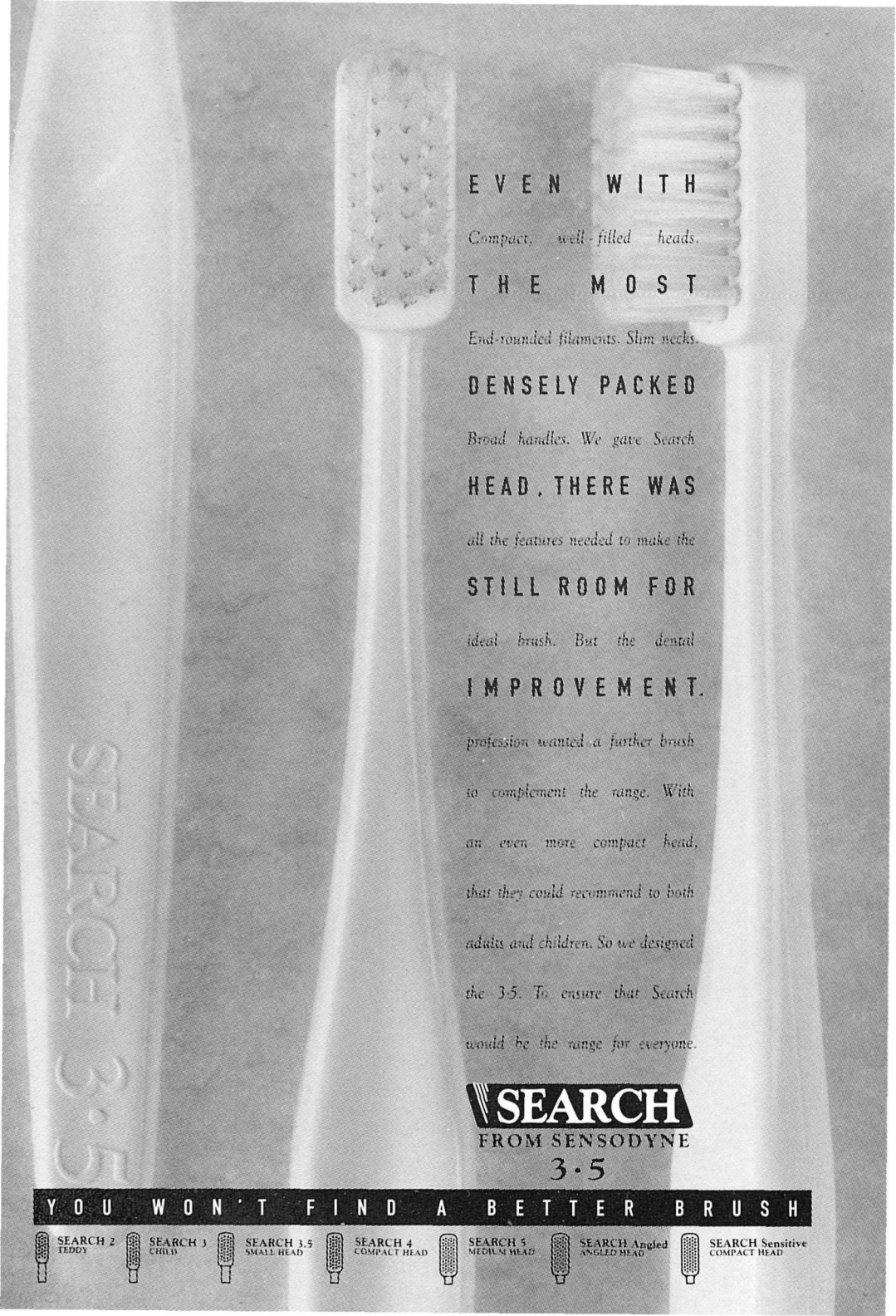
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Volume 105 Number 2417 November 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel 071 955 5000 extn 5413.

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Printed by Hobbs the Printers of Southampton

Passim

It seems that only a very short time has passed since the new clinical students started on their course, yet within these few weeks, one sixth of the medical or surgical firms have been completed. It is stressed that the primary objective is to be able to build on the history taking and examination skills taught in the sixth term inroductory course. The aim though is not just to be able to record information and elicit the signs and symptoms. In addition an element of interpretation has to be applied along the way, to direct the thinking. The big difficulty for the novice is separating relevant information from the irrelevant, and this is due to, dare I say it, a lack of knowledge.

This is an interesting point to consider in light of the criticism of present day medical education which is seen to be trying to force feed students with too much factual material. Why then is there this anomaly? There is no doubt in my mind, even after only having done one medical firm, that one can obtain better 'value for money' from the clinical part of the course if one remembers the pre-clinical. In reality though, generations upon generations of students arrive at the start of the clinical course retaining very little of the first two year's learning—or at least retaining it in a form that is not readily accessible. The blame for this can partly be put on the long summer holiday (or long holidays plus BSc), and maybe even a failure of students to appreciate the benefit of remembering the pre-clinical. A large proportion of the blame must however be put on the pre-clinical course and what is expected of the students. Passing examinations is the crucial element. Much time is spent 'cramming' into short term memory the essay topics that a seasoned question spotter has suggested might come up, and only a very superficial treatment of other areas is possible.

Obviously there is a need to achieve the correct balance between breadth and depth in the basic sciences course, and this itself may be fine in the present course. What does need review is the type of knowledge that is rewarded. Instead of simply reproducing lecture notes, or passages from a textbook, perhaps students need to be taught how to apply the information in a more clinical setting, and then be rewarded for so doing by having examinations that require a problem solving approach.

On a totally unrelated matter concerning the *Gazette* itself. Subscribers will unfortunately have to incur a long overdue price increase from £12 to £15 per annum due to ever increasing costs of publication. A bankers order amendment form is included within the pages of this issue. Whilst on the subject of money, the news item concerning Brooke Lodge omitted to mention that the Friends of Guy's Hospital made the project possible by raising the £15,000 necessary.

SMEC And A Better Education

Dear Sir,

May I bring to the attention of your readers and perhaps yourself the efforts of the Student Medical Education Committee (SMEC) in its pursuit of a better education for medical students. As you will know, there is a continual assessment of the curriculum with increased staff/student cooperation. SMEC is always ready to hear from students and letters should be addressed to SMEC care of Boland House.

May I also add that at the moment I am trying very much to improve communication between students and the UMDS Libraries. It is often forgotten that libraries exist to help us and to meet our needs! If any user medical or dental, staff or student wishes to put forward any ideas, complaints and I hope suggestions then please could they write to me care of UMDS Libraries.

An admirer of our own reform processes.

Yours faithfully,

OMAR RAHIM
UMDS Student Representative
Boland House

Mr 'Joey' Hughes

Dear Sir,

Further to 'Life at Pembury' by Mr E D Y Grasby and Dr Canty's letter regarding Mr 'Joey' Hughes, I well remember my introduction to surgery at Pembury in 1940 as Ward Clerk. Having responded to the call on the recently retired, necessitated by war time shortages, Joey Hughes rose to the challenge to undertake a limited commitment as surgeon but one unlimited as teacher, guide, philosopher and friend to the neophytes in surgery. Not uncommonly, he would appear at the hospital in the evening and discuss routine cases with any ward clerks present. In his ward rounds, the quick mind of the Celt proclaimed (along with his name) that there was doubtless a dash of Welsh blood in his ancestry; his presence riveted the attention of all; no ward clerk or dresser was suffered to 'go into coma', as he succintly put it. The apparent sardonic twist to his humour, however, did but conceal a kindly nature and his homely wit was accepted by all in good part.

Above all, his devotion to the craft of surgery inspired an enthusiasm, which, I think I can say, was seldom lost in those who later embarked on a career in general surgery or the surgical specialities. When I asked his opinion on the worldly wise view that time spent in the operating theatre was of poor value as preparation for the final MB BS, he replied, with a searching look, 'Stay in that theatre 'till they kick you out'. Later, after my demobilisation in 1947, I met him by chance in the grounds of Guy's Hospital; his opening gambit was 'Have you got your FRCS yet?'

I fully share Dr Canty's feelings of gratitude and affection. It was indeed a privilege to have known him.

Yours faithfully,

A W BANKS
5 Slayleigh Ave
Sheffield S10 3RA

National Conference for 'Second Wave' Trusts

A national conference for managers and members of health authorities and trusts is being organised by the NHS Training Directorate at the National Motorcycle Museum on November 21 1991 to debate the issues emerging in the reformed health authorities and first wave trusts.

The Conference, 'New Health Authorities and Trusts—the First Year', will provide different views of the impact of the reforms on the effectiveness of health authorities and NHS trusts. Hopefully this should be a learning process for present and future trusts alike.

Guy's Overspend

The Guy's and Lewisham Trust has predicted a £2 million overspend in its first year.

The trust had already hit an £800,000 deficit after over 6 months of trading, because it has been treating more patients than it budgeted for under the new NHS market system, but is failing to attract extra contractual referrals at the rate expected to balance the finances.

There have been fears that the number of patients being treated may have to be cut to bring down activity levels that have been running 10% above plan, although the trust has said that cuts in services to ease its financial position were not planned.

Congratulations

Congratulations to Mr P M O'Driscoll, head of the Department of Oral and Maxillo-facial Surgery, from his many friends and colleagues on achieving 25 years of service in the Dental Hospital.

As one of the youngest consultants to be appointed in the 1960's, his outstanding surgical skills and teaching abilities have been much appreciated by a whole generation of staff and students and by the patients who have been fortunate enough to come under his care.

Mr P M O'Driscoll

Surviving Birth

A child born in England and Wales in 1990 had more chance of surviving than ever before, according to statistics published by the Office of Population Censuses and Surveys.

The perinatal mortality rate and infant mortality rate both dropped to lowest levels ever recorded in England and Wales, to 8.1 per 1,000 total births and 7.9 per 1,000 live births respectively.

Obs and Gynae—Not So Popular

There is a growing national shortage of doctors entering the field of Obstetrics and Gynaecology, according to the RCOG. The increasing reluctance of doctors to specialise in this field is blamed on litigation fears and poor working hours.

GP Complaints Rise

More patients complained about their doctors last year than in any previous year, according to the Medical Protection Society's annual report.

The most frequent complaints were that GPs failed to refer patients to specialists, and they failed to examine patients adequately. How are patients going to react to the requirement for GPs to undertake more procedures in their surgeries?

Society of Anaesthetists Elections

It is a pleasure to note that Dr Penelope B Hewitt, Consultant Anaesthetist to Guy's Hospital, has been elected as President of the South East Thames Society of Anaesthetists. Also, Dr John R Wedley has been elected as the Society's Secretary.

Guy's has always played an important part in the anaesthetic affairs of the SE Thames Region, including the establishment of many rotational posts at junior level, thus these elections are a welcome recognition of the part played by Guy's.

ADT London Marathon Charities

Guy's Evelina Children's Hospital and the Kidney Patients' Association (KPA) of Guy's Hospital have been jointly nominated as one of the official ADT London Marathon charities for 1992.

It is hoped that the Guy's student body, and the medical, nursing and administrative staff will produce a goodly crop of runners, who we can subsequently feature. All money raised will be divided equally between the two charities, helping the Evelina Appeal buy desperately needed intensive care cots, and Guy's KPA to complete their £1 million appeal for the now Phase III Renal Unit.

Details of the two charities can be obtained from Sylvia Sutton of the Evelina Appeal and Joe Bauch of the KPA.

Halcion Ban

Sales of Halcion the world's best selling sleeping pill, have been banned in Britain since October due to concern over its safety. Nearly 2 million British people use the drug.

The Committee on Safety of Medicines withdrew Halcion's licence after its maker, Upjohn, disclosed it had made errors in a 1972 clinical trial. According to reports, the drug can cause frequent and disabling psychiatric adverse reactions at doses of 0.5 and 1 mg, including anxiety, depression, paranoia, hallucinations, amnesia and aggression.

Friends Christmas Stall and Tombola

The Friends of Guys will hold their customary Christmas Stall on Thursday 28 November from 11.00 am to 3.00 pm in New Guys House. Also a Christmas Tombola in Guys Galleria on Thursday 5 December from 11.00 am to 3.00 pm.

Pay and Display

Parking charges have recently been introduced at Kent and Canterbury Hospital, causing anger to patients and visitors alike. Guy's have recently introduced a pay and display scheme—it remains to be seen how well this is received. However Londoners should be more used to paying for their parking.

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The Czechoslovakian Experience

From holiday to hospital bed

'A cultural experience', I said to myself as I booked my summer holiday to Czechoslovakia, little anticipating the type of cultural experience I was about to engage in.

After the hectic whirlwind of mechanically organised sightseeing (a tin mine—or something similar—I never discovered what and about fifty assorted castles), we decided it was high time for a well earned rest. So after a late breakfast of fish mousse and ryebread, we intrepidly set out to Czechoslovakia's version of 'Club 18–30', the Thermal Pools, reputed for their healing powers and attractive locals. We arrived hot and sticky, but were soon posing in our western shades on the rough concrete slabs around the pool—an ecologically sound green pond, clearly loaded with healing properties! Unable to understand the strange hieroglyphics of an archaic Slovakian Sign, I spent well over an hour examining the vibrio-cholerae encrusted around the diving board—little knowing the impending danger about to strike, spoken of on the peeling sign.

We left the pool for some serious sunbathing away from the concrete slabs, and found a real sunspot overlooking the local sewage works. Too good to be true—a real sun and fun holiday in the Eastern bloc, where beer is 8p and public toilets 15p. (Perhaps that explains the unusual hue of the pool).

I gorged myself on 5 cappuccinos, 3 cokes and a greasy 'Langossa', which was an oily pizza-base covered in garlic; (I later discovered that garlic is the traditional enema in that part of Slovakia). All this added up to 37½ pence—then the D and V struck. It is too painful for me to describe the horrors of the next 24 hours, which culminated in my delirious arrival at Nitra 'Hospital' in a 1967 Skoda manure truck.

I was on the bed approximately 1½ minutes before my clothes were peeled from my body by a well-meaning porter, and I lost my identity to the hospital uniform—a white 'pearly-gates' angel suit. Before long I was being undressed again by another porter, who was also very friendly, giving me comforting slaps on my bottom as he hoisted me onto the table.

'Pre-med' doesn't exist in Slovakian, I discovered as I was clamped onto the table, and the electro-surg kit was switched on. I wondered if 'anaesthetic' existed in Slovakian—fortunately it did.

I woke up to discover the loss of both dignity and appendix, and that analgesics are supplied by demand. Unfortunately I couldn't reach my Slovak-English dictionary, so I spent the evening wondering what had been removed from my abdomen, and counting better ways of spending a Saturday evening. Eventually my whimpers and groans woke up most of the 'hospital', and I learnt my first Slovakian medical term; 'Boodgne'—Pain.

During the next five days, I became 'culturally aware', or rather 'aware of the culture'—their alternative appreciation of the aesthetic; they threw my roses out of the window!

Hospital radio was compulsory—would you like to hear Phil Collins singing 'Another Day in Paradise' all night? I certainly didn't.

Anyway, I lived to tell this story, and it is for this reason that I am launching the Czechoslovakian Hospital Appeal, *not* in order to pay my hospital bill as the rumour goes!

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Biochemistry—Research and Personalities

Prof Diplock, Vitamin E and matters of the heart

The Division of Biochemistry, a combination of the original Departments at Guy's and St Thomas's, now comprises fifteen and a half members of academic staff plus a number of others who carry out full-time research supported by grants. In addition to its primary role in teaching BMS, BDS and BSc courses in biochemistry, the Division carries out an extensive programme of research. Staff members choose their own research topics, however, and this has resulted in the Division spanning a wide range of interests, as is appropriate for its teaching role. Although the research falls naturally into a number of interconnected areas, its total scope, which includes that of a further fifty, or so, postdoctoral and visiting staff, research assistants and postgraduate students, plus a small band of technical staff, is far too extensive to be compressed, with any degree of comprehensibility, into one article. This, then, is the first of a series of short articles covering the main interests.

It is appropriate to look first at the activities of our Divisional Chairman, Professor Tony Diplock, now recognised as an international expert on anti-oxidant nutrients including vitamin E,—α-tocopherol, as it is known in the trade—and the trace element, selenium. The two topics are frequently lumped together because of their common involvement in preventing unwanted cellular oxidation processes, particularly of membrane polyunsaturated fatty acids. Although this may be central to their activity, their metabolic involvement goes far beyond this, as is revealed in this review by their involvement in a range of issues they have stimulated. In passing, it also demonstrates how the interplay of chemical and cellular investigations and, indeed, the study of the whole individual, are fundamental to modern biochemistry.

Among the vitamins, the importance of vitamin E was slow to be recognised and when Tony first gave it his attention, upon joining Vitamins Ltd many years ago after doing a PhD at Guy's under Professor Haslewood, the most expansive remark to be found in a biochemistry text-book was that its absence caused sterility in rats while it was probably unimportant in humans! Moving to the Royal Free Hospital Medical School, Tony and Professor Jack Lucy made the seminal observation that vitamin E was not just a biological antioxidant. They suggested that by altering the structure of biological mem-

branes, it probably played a significant and specific role in modulating the enzyme activities by which unwanted oxidation was prevented. Since returning to Guy's, Tony has refined the method for detecting small amounts of the vitamin in biological tissues and this has opened the door to studying its functional role. It soon emerged that vitamin E had a crucial stabilising influence on the important glutathione oxidation-reduction (redox) system via glutathione transferase and selenium-dependent glutathione peroxidase. Other work, with Dr David Watts, showed that the activity of liver glucose-6-phosphatase, the membrane-bound enzyme involved in mediating the release of glucose into the blood, was also affected by the dietary levels of vitamin E and selenium.

Most students, warned of the highly toxic nature of selenium in relation to its use as a fixative for electron microscopy, received the idea of it being essential for human well-being with amazement, if not disbelief! Nevertheless, it was just this problem that took Tony in an advisory capacity to China where large tracts of selenium-deficient land result in the local population suffering from Keshan disease and Kashin-Beck disease. The former is a cardiomyopathy and the latter an osteoarthropathy (Figure 1); both diseases occur in large numbers of children and young adults in these areas. This led his then PhD student, Chris Goldring, to spend four months there, collecting samples and studying the biochemical basis of the problem. Treatment of patients is now readily achieved with a combined weekly dose of selenium (1 mg) plus vitamin E. Domestic animals are also affected, a problem of commercial importance in this country, but administering the correct dose has proved more difficult. Although not a part of Professor Diplock's research, it is of interest that, recently, the united efforts of the Wellcome Foundation, Pilkington Glass and Leeds University have resulted in a silica-free 'glass', a bolt of which can be easily 'shot' into an animal where it slowly dissolves to supply the correct daily doses of selenium, copper and cobalt for one year. Facing the 'firing squad' may open the way to new forms of human therapy!

Equally exciting is another discovery to emerge in the last few months. The involvement of selenium in thyroxine metabolism had been suspected for some time. As a result of collaboration between Tony and Professor Jacques Dumont and Dr Jean Vanderpas of The Free University in Brussels, international experts on thyroid metabolism, it has emerged that certain populations in Zaire, identified as thyroxine deficient, may suffer the additional complication of selenium deficiency. This observation has led to the discovery that selenium plays a key role in enzymes associated with the deiodination of the iodine storage hormone, T4, to the active hormone, T3. Thus, yet another medically important metabolic pathway unfolds for students to groan about in the future!

Figure 1: A patient with chronic Kasbin Beck disease from Yi-Jun in China. Photography by Dr C Goldring

The toxicity of oxygen has been known for many years and, back at the bench, attention has turned to analysing the possible importance of free radicals (which contain reactive unpaired electrons) in the pathogenesis of malignancy. Dr Chris Goldring and Dr Ram Rao have compared control and malignant ('transformed') cell lines and have found that while vitamin E may preferentially enhance the growth of malignant cells, growth is markedly inhibited by selenium. These results are encouraging and the work is being extended to include other antioxidants and other cell lines to determine the general applicability of the finding.

Collaborating with Professor Diplock in the work on malignancy is the Division's newest member, Dr Catherine Rice-Evans who replaced St Thomas's Professor Bachelard. Catherine, also from the Royal Free HMS, is exploring the involvement of free radicals in a variety of pathologies; summarised next is the vigorous research team which she runs on the St Thomas's campus.

Dr Vidya Udupi, who is supported by Bioxytech in Paris, although known romantically as the group's 'French Connection', nevertheless has down-to-earth interests. She is examining the regulatory mechanisms by which cells maintain adequate levels of the endogenous compounds which combat free radical formation. This is truly fundamental biochemistry—how normal cellular processes are activated or enhanced.

Rebecca Furness, by contrast, has an applied medical problem—the loosening of artificial hip implants in individuals with arthritis. This work involves collaboration with Dr Michael Davies at the University of York. The objective is not only to understand the underlying biochemical involvement but also to design drugs to prevent or alleviate the damage associated with the loosening. Computer-aided drug design is one of the house-specialities at York.

Also on the St Thomas's campus, Catherine and Andrew Hartley are studying the involvement of free radicals in the clogging of arteries with fatty deposits. It is suspected that this cause of atherosclerosis results from the uncontrolled oxidation of blood lipoproteins.

Finally, we turn to Catherine's very important study of coronary heart disease. Determination of the significance of free radical-quenching nutrients (such as vitamin C, vitamin E and carotene), as protective agents, is the daily round of Nick Miller, Nida Salah and George Paganga. Attention is being particularly directed towards methods for assessing early warning signals for a predisposition to heart disease and their relationship to the blood nutrient levels of those at risk. Also involved in this work is Emma Newman but her angle is the design and development of drugs for treating myocardial infarction. Arising from this work patents have just been filed for a diagnostic test for susceptibility to heart disease and for a drug for its treatment.

These last two investigations provide a new link with the work of Professor

David Hearse's Cardiovascular Research Unit in the Rayne Institute at St Thomas's Hospital. The Cardiovascular Research Unit, although falling within the Division of Biochemistry for administrative reasons, with which it has a strong biochemical connection, is a self-contained independent organisation. Founded in 1976, its greatest claim to fame is the development of the 'St Thomas's Hospital cardioplegic solution', a fluid which rapidly stops the heart beating and keeps the muscle relaxed for easy surgical manipulation. This largely prevents the damaging consequences of oxygen deprivation, energy depletion, and so on, that would otherwise occur in situations where the heart has been isolated from its normal blood supply during open heart surgery. The 'solution' extends the viable life of a isolated heart to about five hours, allowing operations that would otherwise be impossible. Professor Hearse has made his discovery available without patent protection and it is now used worldwide. Although the 'solution' has saved countless lives it is his ambition and that of his team, led by Dr David Chambers, to extend viability to twenty-four hours. A longer period of viability would reduce the requirement for 'emergency' surgery for heart transplantation and greatly increase the availability of hearts fulfilling particular tissue-type requirements.

One problem with the use of the 'St Thomas's solution' is that it is less effective with young hearts. The reason, so far unresolved, is under intense investigation at the present time. David believes that as many as half the operative deaths in children could be prevented if a special solution for infant heart surgery could be developed.

One of the major causes of sudden death following a heart attack is the development of disturbances in the electrical rhythm of the heart (cardiac dysrhythmias). One of David's research teams, led by Dr Michael Shattock, is investigating these fatal disturbances of the electrical activity of the heart. Michael, an electrophysiologist, is studying the electric potentials associated with ion movements—sodium, potassium and calcium—across cellular membranes in the normal heart and when it is under stress, either in disease or during and after surgery. This is fundamental research as the complex role of calcium ions, which move into and out of the heart cell, as well as across the sarcoplasmic reticulum, in the course of contractile activity, is still only poorly understood. Associated with this work is Dr William Coetzee, an experienced electrophysiologist from South Africa.

Another member of David's team, Dr Metin Avkiran, is investigating the pathophysiological basis of cardiac rhythm disturbances which follow the blockade and subsequent opening of a coronary artery, and how these are affected by other disease states such as diabetes and high blood pressure. With his background as a pharmacologist, Metin is also studying the treatment of these arrhythmias with drugs. An additional interest of his group is the

study of cardiac growth in the newborn, both during normal development and following the imposition of a work overload, and how the response of the heart to periods of blood deprivation is altered by abnormal enlargement.

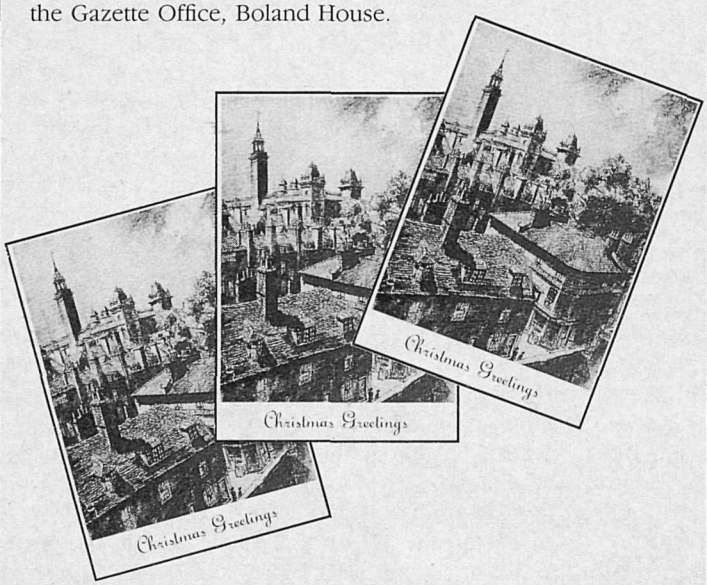
These researches illustrate both the need for continuing discipline-based fundamental research and for the integration of disciplines to extend our present understanding of biochemistry with respect to both age and physiological status. They pose a formidable challenge; the repercussions for medical education are already being felt.

Dr D C Watts
Reader in Biochemistry

Gazette Christmas Cards

Gazette Christmas cards are now available. The first (shown below) portrays the painting 'The Ship and Shovel' by Hanslip Fletcher, which dates from 1912. The second card depicts the Guy's Hospital main gates. Both cards are printed in black and white and measure approximately 5½" by 8½".

The price is 35 pence per card, with a flat charge of 70 pence for postage and packing. Personal callers welcome at the Gazette Office, Boland House.



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Clinical At Guy's

Making the move down from Cambridge

At the end of my second year at Cambridge, I had to make a decision about where I wanted to do my clinical training. I had a choice between staying at Cambridge, going down to London, or across to Oxford. I chose Guy's, purely and simply because I've always wanted to come here, ever since I decided to do medicine.

In that Christmas term at the beginning of my third year, I came down to interview at Tommy's where I was asked about ladies cricket, the Varsity match, and everything else but medicine. Luckily I was offered a place and really looked forward to it for most of the year. But when finals were over, and May Week began in Cambridge, I seriously started to have doubts about whether leaving glorious sunny decadent Cambridge was such a bright idea.

However, over the summer the attraction of Guy's and of a totally new place took precedence over nostalgic reminiscences about Cambridge, and I looked forward to starting at UMDS on 3 September. The Oxbridge course lasted for four weeks before the clinical course proper and I really enjoyed it. Dr Rees patiently showed us how to examine, and how not to, starting with each other at first, until the last day when we were finally let loose on real patients, who put up with us graciously. During the two weeks, we convinced some people they had 10 inch livers, then that they had no heart sounds, and Mcleod's syndrome seemed to feature prominently in our differential diagnoses (one of the patients kindly obliging us during the history), though none of us have since heard of it.

After the Oxbridge course I joined the rest of my firm at Lewisham. All I remember of my first day of my first clinical firm was sitting in the canteen, writing out notes that I didn't understand and working out how to use the somewhat flashy coffee machines.

I really enjoyed the firm though I remember that I was repeatedly berated by my consultant for my inadequate presentation, and for other indiscretions such as admitting that I hadn't a book on physical signs and promptly being told to get off the ward until I did. The firm was relatively relaxed, though take-in was quite busy. The only problem I had was that although I was fine in most operations, in any operation that involved structures between the inguinal ligament and the medial compartment of the thigh, I found myself the unwitting victim of a vasovagal surprise. (This was somewhat embarrassing seeing I was doing a urology firm).

After this, we moved to Guy's for our first medical firm, which I also enjoyed. The consultant's ward round on a Tuesday morning was anticipated with some trepidation, partly unjustified. The consultant would ask you questions, which you answered hopefully, but were left hanging on not knowing whether what you had said was even vaguely true until right at the last moment just when you were sure you were a goner. Cardiology was interesting, through I think the poor patients were somewhat surprised to find that when the consultant asked politely 'Would you mind if some of my medical students come in?', he actually meant 12 white coated novices, who reapeatly (week-after-week) managed to knock the nursing equipment into the sink, just at the moment the consultant was attempting to auscultate the faintest of mumurs.

Towards the end of the firm in January I started to feel rather home-sick, that is, missing Cambridge, mainly because of its greenness, its beauty, its quiet, and its breathable air. But a couple of visits back soon enlightened me that these superficial reasons were not the basis of my longing for Cambridge. Cambridge as a place is beautiful and ancient, but it was not the place but the people that I was missing, and most of those people had graduated along with me, and so had also left. Without those people, Cambridge was not so special after all. I realised also that Guy's too would become as special as Cambridge, but not so much for the place, more for the people.

After this bit of soul-searching in January, I've never really looked back at all, only going back to Cambridge once, for the May Ball.

I have made many friends here at Guy's (and some at Tommy's—sorry!), but it has to be said that it is difficult coming into a year, in which everyone else has known each other for two to three years already, to try to make new friends. Most are very welcoming and go out of their way to make you feel at home, but there is a feeling somewhere in one's mind of being an invader or an outsider. The Oxbridge course doesn't help this feeling because it builds up a clique into which one can crawl back defensively when the rest of the clinical year join up. However soon I lost my Oxbridge roots, and while I love Cambridge and I always will, I am living in the present and I now feel I am becoming a Guy's man, though it may take some time still for me to be accepted as such.

I have just finished my psychiatry quartile in which I had attachments in Brixton and Lewisham, and perhaps I am entering the real world at last. Cambridge is an artificial world, full of upper middle class students, and academics many of whom have lost touch, partially at least, with reality. The other part of these academics is actually more in touch than anyone with reality. But the side of Cambridge that is encountered by the undergraduates during their three years is definitely one of an artifical existence for 24 weeks

of the year, with formal halls, gowns, early morning rowing outings, the Lent Bumps, Suicide Sunday and garden parties, Cuppers cricket, high table, the Master and his wife, the May Ball, and running around the quad at 3 a.m. in your boxers. These things are all marvellous to experience but after three years, one needs to see the outside world and thus enjoy a wider horizon of experience. Cambridge is not the real world and never will be but it is a jolly nice fantasy world that it is certainly worth experiencing for three years (or more). Although in some respects it might be pleasant if one were at Addenbrooke's to have the harsh reality of life presenting itself at A and E on a Friday night after 'townie raving' in the market square on the one hand, while on the other being able to retreat into the comforting hedonistic and architectural existence of the quad over the weekend, closeted in one's college cubby hole, one is still distanced from '*la vie vrai*'. In London the demarcation is not so distinct. Life is more uniform in its variation, the stark contrast in existence of town and gown does not prevail.

Less seriously, the life at Guy's is excellent. The hops and inflams speak for themselves (which do you prefer—Elijah or Neville—take your pick!). The freshers are welcomed with friendliness and a week of raging, partying and staying horribly drunk for a week.

Away from Guy's, there is the whole of London to explore. I myself have lived in London for 17 years but I am only now starting to realise what London is about—walking back from Trafalgar square at 3 a.m. because you've got no money, watching plays and films on the South Bank or at the Barbican, joining in the Hospital Bumps, traipsing around on Hampstead Heath, going to the markets in Greenwich and in Brick Lane, checking out the Indian places in the East End, watching the soccer at Highbury (when you can get in), nipping off clerking duties to watch Wimbledon, or cycling down to Richmond Riverside on a Sunday afternoon. Many of these things I had never done despite my seventeen years in London.

On a more academic note, there are a few points I would like to make. The pre-clinical course at Cambridge is intellectually very good, but vocationally very poor i.e. if one likes pure theory and pure research then Cambridge is superb, but if like most of the medics, one studies theory mainly so it can be applied to save patients lives and improve their health, then Cambridge is poor because it lacks the clinical emphasis to subjects that otherwise may be dull. At the end of my third year I was standing at a concert and someone collapsed in the row next to me. I could do nothing despite my friend's comments of 'You're a third year medic, do something'. The tragedy of the Cambridge course is that you do not lay eyes on a patient for three years. This situation must change. I think there must be a mandatory first aid course as part of all pre-clinical courses.

Unfortunately, currently people go up to Cambridge full of enthusiasm for medicine but don't get taught any and lose interest. Learning anatomical and biochemical pathways is boring unless one is also taught or demonstrated the clinical aspects. This approach is currently being attempted by Guy's and other London medical schools.

With respect to the Guy's clinical course, I have enjoyed it immensely, but can see a few possible improvements. Firstly, the issue of the eleven week gap after the first two firms; just when I was getting into clinical medicine and seeing patients, I was torn away to do pathology and M2/S2 and as a result all the enthusiasm I had going slowly ebbed away. I think that while it is important for us to learn the path, it is more important to retain the drive we pick up in the first two firms for more clinical medicine. Ideally we ought to do a little more general medicine and surgery before we launch ourselves into the quartiles, so that we have a decent grounding in basic history and examination before we attempt to specialise on a background knowledge and expertise we have not yet adequately gained.

The Cambridge course offers one idea that I think may be useful. Every week throughout the course one's clinical supervisor takes a group of 4–5 students no matter what speciality each is doing, to see a patient. One of the group examines and presents his findings. In this way not only are basic history and examination drummed in, but also any disease or signs that the students may not have seen previously are frequently seen in these sessions.

Though I have presented Cambridge and Guy's as such disparate places, in reality there are many overlapping features, but in this brief space I have not the room to discuss these. I am very glad I came down to Guy's from Cambridge, though as I have described there have been moments of doubt. In the future, I think that rather than the tradition of Cambridge first and then Guy's, perhaps the possibilities of Guy's to Cambridge should also be considered.

Yousuf Karim

Symposium on Vascular Surgery

To mark the retirement of Frank Ellis, MS, FRCS

It seems fitting that in the 150th commemorative year to mark the death of the great Guy's surgeon, Sir Astley Cooper, that the Symposium on Vascular Surgery should be held at Guy's to mark the retirement of another great Guy's surgeon, Mr Frank Ellis.

This event was well attended by not only surgical personnel, but medical consultants and students as well. They were rewarded by six fascinating presentations covering areas of particular interest to Mr Frank Ellis.

Mr Peter Taylor opened the symposium with an update on the need for, and cost effectiveness of, graft surveillance, together with methods of achieving this and for how long it should be undertaken. It seems as though any graft that is going to re-occlude will do so within the first year, and after that time there is an annual 2–3 per cent loss due to progression of the underlying disease process. Interestingly, he pointed out that although the actual cost of finding and repairing a stenosed graft was approximately equal to that of an amputation, in reality, when rehabilitation costs and quality of life were taken into account, it was infinitely cheaper to have a graft surveillance programme—a point he hoped would be appreciated by business managers!

Dr John Reidy gave an informative presentation on Developments in Vascular and Interventional Radiology which indicated that the future lay in intervention rather than diagnosis. For students it was the definitive guide which lead neatly on to Dr David King's presentation on Run-Off Assessment: Can Doppler Ultrasound Augment Digital Subtraction Angiography? Both consultants have been working closely together to correlate their findings and, with some minor wrinkles still to be ironed out, it seems as though doppler ultrasound will be the diagnostic tool of the future.

After the break, Dr John Shaw, presented Studies in Transplant Rejection, which he had undertaken using rats as a model. 800 heart transplants later, he showed that aspirin seemed the most effective means of prolonging the life of a graft—although the doses required in human terms would be massive. He also showed that the nephrotoxicity of Cyclosporin A could be reduced by the initial use of Azathioprine and Prednisolone in patients who did not produce a good urine output within 6 hours of receiving their cadaver transplant. Once these patients were producing a urine output of 500 mls/

day, Cyclosporin A was introduced gradually with good results.

Professor Michael Horrocks then presented Aneurysm Surgery—Past, Present and Future, which made one wonder how anyone progressed past the first few patients. As with many advances in medicine, many great names were involved, starting with Sir Astley Cooper as the first man to ligate an aorta—the patient lived three days—but then, this was in the early 1800's. Fortunately, with modern materials and methods, patients tend to have a better outcome, although along the way patients seem to have benefited from some very bizarre approaches, eg the patient who lived 10 years after his aortic aneurysm was filled with 200 feet of tangled fine wire fired from a special gun! Mr Horrocks also noted, from his personal observations, the correlation between horseshoe kidneys and aortic aneurysms—a possible project for some student?

The last presentation of the Symposium was from Mr John Maynard who gave a fascinating account of the life and times of Sir Astley Cooper and vascular surgery. Actually, there was little of the latter, as Mr Maynard felt we had seen many aspects of the subject well presented during the afternoon, however, a comprehensive account of Sir Astley Cooper's life was forthcoming. Anyone who knows the whereabouts of the elephant skeleton originally dissected by Sir Astley which eventually made its way to the Gordon Museum and has since disappeared without trace, should contact Mr Maynard directly! He ended the dissertation by reminding Mr Ellis that Sir Astley had enjoyed a long and fruitful retirement, during which time he was appointed President of the Royal College of Surgeons on no less than two occasions! You have been warned . . .

The afternoon was rounded off by Mr Ellis who seemed to appreciate the many kind tributes paid to him by his colleagues and having thanked them all, went on to wish Mr Peter Taylor all the best in his new post.

E A Hoskins

Politicians Face The NHS

BMA Medical Students Group expects answers

Over the past two months, the party political battle over the NHS has exploded onto the media scene. Since the party conference season, you can rarely open a paper, turn on the radio or watch TV without some aspect of the NHS coming under close scrutiny. In short, the issue of the NHS has erupted and looks likely (if polls are anything to go by) to bring down 13 years of Conservative government. Into this fevered atmosphere, the Royal Free BMA Medical Students Group invited the parliamentary candidates for Hampstead and Highgate to present their party's policies for the NHS. With impressive timing, 'Issues facing the NHS' took place just before the announcement of the second wave of Hospital Trusts—timing that ensured and extensive audience.

That audience congregated in the Royal Free's Peter Samuel Hall. Why such a large crowd? It always surprises me that such meetings are so well attended. What do people expect to get out of them? After all, all they will hear are the usual political nostrums which they will have heard many times before. As this particular evening got underway, the answer to my question became clear—people came to put the boot in!

The first speaker was the Conservative candidate, Oliver Letwin, a youthful, black-haired, ruddy individual, sporting a smart suit and striped shirt. This merchant banker is an author of many of the privatising proposals that issue from the Conservative think-tank, the Centre for Policy Studies. Proposals which include the Community Charge (Poll Tax) and Ideas for Radical Reform of the NHS. In his own words Mr Letwin is a privatizer 'par excellence'. So what did he say? Much what you'd expect—he kicked off with the statement that the Hospital Trusts, General Practice Budgets and the Internal Market would offer improved patient care and choice, providing Trust hospital statistics to back this up. Then he mentioned the results of ballots carried out in hospitals about to apply for Trust status showing that consultants support the application. The NHS would not be privatized, Mr Letwin claimed—but not because he was against privatization; to emphasise this point he listed all the other privatization deals that had got his blessing! The main reason the NHS would escape the net, he explained, was that the 'lumpy profile' of the health care 'commodity' made it unlikely to respond to the action of market forces.

Mr Letwin gave his views candidly, and made it clear that he was determined to brook no equivocation. He stated his claims with both power and conviction.

However, the outburst of indignation that greeted his comments showed that hardly anyone believed him. This was the first time I've seen a Conservative candidate reduced to the defensive, and it did him no good. I think Mr Letwin may privately regret the passing of Margaret Thatcher.

Next came the Labour party candidate, Glenda Jackson, fresh from her first conference speech and with the considerable advantage of being a celebrity. When I asked some members of the audience who was going to speak, they said 'Glenda Jackson and some other people', asked afterwards who were the speakers they said 'Glenda Jackson and some other people'. So just what did she say? Much what you'd expect. The Conservatives were privatizing the NHS by the back door, she said, rather than by a public share auction. She cited prescription charges, dental and eye-test fees as evidence, she talked about the increasing number of private patients being treated in NHS hospitals, and presented a variety of other statistics. Her message was that the NHS is being privatised and you can't fool us. She went on to attack the Conservative's record on social security, poverty and housing, finishing up with a fine piece of electioneering: 'the NHS will only be safe in Labour's hands—because they put it there and they care about the people who use it'.

The Liberal Democrat candidate, Dr David Wrede, was next. Being a doctor was a considerable advantage for him, he couldn't have wished for a more sympathetic audience. (It came as a big surprise to me to hear that he was trained at St Thomas's—a Tommy's man who's a Liberal Democrat!?). What did he say? Like the others, he said much what you'd expect. Both of the other parties were wrong, he claimed, and had no answer to the NHS crises. Proportional representation only was the way forward, this would allow a local population to gain genuine power over their own health service. After these niceties, he climbed onto the fence (in my opinion)—he gave no assurance that his party would repeal Trust status or maintain Trust status. Then again, does it really matter if he does sit on the fence? In response to Dr Wrede's electioneering 'When the Liberal Democrats are in power', a wag in the audience shouted 'We can't wait that long!'

Last, but by no means least, was the BMA representative, Mr John Chawner, chairman of the Central Consultants' and Specialists' Committee. He had the considerable benefit of being the only speaker with a good suntan, which helped him to look the healthiest person on the platform. Now what would you expect the BMA representative to say? He announced that the BMA was apolitical, then put the screws on and asked the government to put the cash upfront! (Sorry, just a joke!) What he actually said was that the BMA was an apolitical organisation and that it was always difficult to avoid endorsing particular political parties in an election year. However, the CCSC felt it had a duty to speak out against the current reforms, said Mr Chawner, as they

were felt to interfere with the delivery of health care. He also offered some interesting asides on the horse-trading that goes on between consultants and managers when a hospital is applying for Trust status. The current NHS reforms were an experiment that sprang from a chance remark by Margaret Thatcher, he said, and these untested reforms jeopardised the whole service. He ended up by saying that the BMA Economic department estimated that a further £6–8 billion was required to bring NHS funding in line with that of equivalent European organisations. In other words, he announced that the BMA was apolitical, then put the screws on and asked the government to put the cash upfront.

Question-time came next, and with it what the audience had been waiting for—the chance to put the boot in. Mr Letwin correctly predicted that he would be the target of the most of the questions and took hold of the microphone. Then the chairman of the meeting, Professor Dennis Chapman, provided some light relief by referring to microphones as microscopes and juggling with a few of them. After a few questions to Mr Letwin, Professor Chapman insisted that questions were directed at other members of the panel—he obviously couldn't stand the sight of someone being kicked when they're down!

Mr Chawner asked Mr Letwin if, as a merchant banker, his bank would be prepared to invest £500 million (the administration costs of the reforms so far) in an untested scheme and, if so, whether the bank could expect to keep its investors. The reply from Mr Letwin was yes he would, and gladly—but then he had to say that, didn't he? Mr Chawner also asked Ms Jackson whether the Labour party would provide the £6–8 billion the BMA insisted the NHS required. She said she couldn't give concrete assurances, but more money would be forthcoming—if there was any money left in the Treasury, given the way the Conservatives were spending it—but then she would say that, wouldn't she? The celebrated actress then gave an emotive description of a 90-year-old-woman crippled by rheumatism, unable to feed and care for herself, abandoned by the Conservative-controlled NHS. Mr Letwin replied that he couldn't match such rhetoric (which he couldn't). He then attempted to criticise the last Labour government bringing derision from the audience, the last Labour government being beyond living memory. At this point Mr Letwin resigned himself to his fate, saying that people were only directing questions at him until he made a stupid mistake (which, to be fair, he didn't). All in all, it was rather good of the BMA, campaigning strongly as they do against boxing to provide an alternative blood sport.

So now I return to the question of why people attend political meetings. For me, the early part of the debate was disheartening. The NHS seemed to be viewed by all parties as a political object to be pushed one way or the

other for the party's gain. What really disappointed me was the absence of consensus upon the way forward in such a negative climate. The Conservatives wanted to continue to subject the NHS to untried experimental reforms, with no guarantee of success. The Labour party seemed to want to return to the way things were in the 1970s, with only a casual nod to the fact that things have changed. And the Liberal Democrats, just what were they proposing? It appeared to be some vague third way that somehow involved proportional representation. To Mr Chawner's credit, he brought the discussion around to specifics such as the desirable outcomes of reform, to underfunding, efficiency and patient choice, to the role of the future NHS.

In spite of all this, there was one positive outcome of the meeting. As the debate drew to a close, there was a recognition of the critical roles that poverty, housing and income support play in health issues, and that the NHS is not the sole guardian of the Nation's health.

Laurence Reed

'Obs & Gobs' in 1968

The changes and the similarities

It was said once that there were only four operations a gynaecologist could do: the hysterectomy, the repair, the D&C, and the cutting of either/both Ureters. And, for the first time in my life I would have to face up to women—or rather, I would have to deal with their nether regions in the clinical sense. I suppose the student of today would hardly blink at the thought of such a task but for a shrinking violet like yours truly, the thought of dealing with women's privates filled me with abject horror. They could have been the Gates of Hell as far as I was concerned, but thanks to the kindly expertise of David Morris, the whole experience was made easy for us. From him, we got the full tour of the areas which had remained mysterious for so long. In fact, the department was very well endowed with household names.

There was G F Gibberd and I bought his book *Short Textbook of Midwifery* which was—by then—into its eighth edition. I remember him very clearly. He'd stand there with his hands in his pockets, in a three-piece suit, gold-rimmed specs, and a pipe from which smoke perpetually puffed as though they might be electing a new Pope every five or ten seconds. I never heard him speak but he appeared intensely wise and had the look of a man who had survived all the obstetric scrapes in this life through sheer mastery.

There was a very reassuring man called J A Blaikley. He was bald and friendly and appeared to be smiling whenever I saw him passing through the Colonnade. We also had T L T Lewis. He was very muscular and had the look of a man who had played a lot of rugby. In theatres he moved with a slow deliberation through the tissues completing his procedures at considerable speed. J S Tompkinson was noted for his size 6½ hands and he could make babies appear as though by magic before the inept dresser could get scrubbed up properly. He had the knack of starting without you when it came to the elective caesar and if you blinked you'd have missed the whole thing.

Such were our teachers—and how lucky we were. I'm sure they're just as good these days but those years in the sixties were rather special. We seemed to be imbued with all the dab hands in the game.

The Obstetric Dresser was supposed to chalk up eight deliveries and the first delivery was a matter of some strain. We had to wait to be on obstetric take-in before our turn came. The Midwifery Sisters on Victoria Ward, Hunt's House, made life very easy for us. All of them appeared cool, calm, and

collected. It was the way they did an episiotomy that really gave me the willies. Those ladies could do such things with all the assuredness of a short-sighted Rabbi with his eyes shut. On the occasion of my first delivery it was a hot day in July when I donned the mackintosh-apron, gown, gloves, and hat. At the same time, by sheer bad management, I happened to be wearing a three-piece suit—but we did in those days, you see—and such was my nervous excitement, I had forgotten to take off my jacket. The whole thing was rather messy—as I remember—and I gave a thoroughly inept showing—and there were hands—*everywhere*.

If I'd been left to get along all on my own, I'm sure it would have gone just as well but it seemed that there was a lot of pushing and shoving going on: cries of 'push Lovey!'; moans, groans, and the like—and then the head was there and I had a gloved hand in there somewhere but there were other gloved hands there too and talk of the anterior shoulder—and *whoosh*—a gush of that liquor with the never-to-be-forgotten smell, and—*hey presto*—the baby.

If that counted as my first delivery, then I felt as though I had got in the way, but at the time it *seemed* like my first delivery and—by golly—when I took off all the clobber that it was customary to wear, I found that I had completely soaked through my three-piece suiting and that a trip to the East Wing for a bit of a sit-down in the common-room was called for.

They let me deliver the afterbirth, though. That came as something of a disgusting surprise although we had been warned, of course. I have never really been able to get my act together enough to share the feelings that holding a freshly-delivered warm placenta invokes in me.

J S Tompkinson was once asked how soon after having a baby it was safe to make love; and he, dear man, replied that a gentleman always waits for the afterbirth! It must have been an old joke then but it still makes me laugh now.

We had to carry a bleep, of course, and I felt somewhat wary of the thing. It tended to go off whenever I was sitting comfortably on the loo with my *Daily Telegraph*. It was rumoured that these bleeps were very expensive and there were already tales going about as to how one or two chaps had thrown theirs into the River Thames whilst in a fit of pique and exhaustion. As far as I was concerned, it was the bleep of the deliverer because after that first one the whole business was—as they say—a piece of cake. For the first time in my life I felt suffused with a sense of confidence as if I might have been touched by The Almighty. This ego inflation (anagram is 'feel a tin god!') soon passed because as a student it was never a good day unless some consultant or registrar had crapped on you from a great height for some minor incursion

of the rituals that surrounded all those everyday businesses that are the lot of the busy *accoucheur*.

Those weeks on obstetric take-in were filled with bleeped requests to attend the ward for episiotomy repairs. The first time I ever repaired an episiotomy I have to admit that much of what I was looking at was guess-work and I challenge any ex-student to deny this feeling. The basic structures were easy enough to identify but the idea of performing a repair in three layers became something of a mystery when the whole scene resembled one of carnage. The ladies—God bless 'em—took it terribly well; calling out from their end of the bed that: 'You'd better do a good job on me or me 'ubby'll be after you in six weeks!' Other conversations along the lines of: 'Do you come here often? Only during the mating season!' Some tried to go further; 'I expect you get rather tired of looking at women, doctor?' 'Eh what? Oh my gosh yes—absolutely! What was that you said, Madam?'

Really—when one thinks back about some of those repairs it's a mercy that the human frame is so forgiving. We'd been shown a film, of course. The operator there was a mass of flying hands and everything fell into place under the spell of his wondrously-gloved digits. Truly, the quickness of the hand deceived the eye—and that was how an episiotomy repair should be done.

Things have changed much since then. We have epidurals and all manner of electrical equipment. Labours are shorter. The days of being on the labour ward for two or three days are long since gone. I have at home a grisly collection of instruments my grandfather, William Pitt-Payne, used in the perusal of his home deliveries. In the early part of the century and before, it was considered rather bad form if the GP couldn't deliver his own patients at home. His assistant, Dr Dorothy Gibbs, told me that dismemberment *in utero* was not unknown to her and I have a wicked pair of craniotomy forceps and an instrument long ago consigned to the museum—the perforator. From time to time I hold these horrific instruments in my hands and wonder at the dreadful occasions when they must have been used. Dorothy Gibbs used to regale me with the horrors of maternal deaths that had occurred. I asked her the cause; 'Clots—it was usually clots', came the reply. My grandfather had won the Gold Medal in Obstetrics at the Westminster Hospital in 1899—or thereabouts. There are still many of his babies living in the vicinity who remember him in his pony and trap—and the top hat, of course.

He had a Gladstone bag and carried the baby to the house—so the story went if children asked him what was in it. Apart from the afore-mentioned instruments, I am pleased to say that he did have a pair of Neville-Barnes axis traction forceps and a trichlorethylene apparatus for giving relief from pain whilst he operated.

There was a gynae outpatients on Wednesday afternoons that we were expected to attend—and on a hot summer's day the whole thing could be a bit oppressive—for reasons I need not entertain you with here, but those who were there will know what I mean; the funny pong—and all that, eh what? And the apocryphal story about the medical student who had spent overlong examining the West Indian lady of thoroughly voluminous proportions who said; 'If you don't hurry up and finish, boy, you're gonna ring my bell!' I've always put that one down to Fritz Baker—at least, that's where I think the story came from.

Part of my elective was spent at Farnborough Hospital and so much did I like it there that I went and did the SHO job some three years later. As students our tasks were simple but necessary; like changing the oxygen bottles when they were empty and sewing up every episiotomy going. By the time I was done there, everything looked a lot clearer. My mentor was Tubby Evans and no one before or since has inspired as much loyalty as that man. There are many stories to be told about him but all I shall say is that we worshipped the ground he walked on. He insisted on the highest standards—and got them. As a student—and later as his SHO—he helped round off my medical education. Nor should I forget the registrars and senior registrars; men like E P W Tatford, Mike Patterson, James Moir Shepherd, Mike Terry, and Guy Nash—all of them quite unique characters and now consultants of many years standing.

And there was the Midwives Flat. Who can forget the Midwives Flat? The student midwives were already SRN; came from other hospitals in the main, and were extremely friendly. We were forever using their gas stove to make omelettes with eggs taken from all over the shop. Gubby Morsman, poor devil, had the misfortune to lean up against a hard wall and feel the eggs breaking in his pocket. We got most of the mess out of his pocket and into the pan and made a somewhat fluff-ridden omelette. His jacket can't have been the same afterwards but such details didn't seem to matter in those days.

Who can ever forget those mind-numbing mornings in some stuffy little laboratory where we tested for protein in the urine? The antenatal clinic was on the ground floor of outpatients—as was the laboratory. Today, there are wee stick things—all different colours—but in the sixties and before, generations of students had boiled urine in test tubes over bunsen burners to test for albumen. If the heated pee went cloudy then that was a chance to get out of there and show it to some weary registrar. Frequently, though, we would be chatting and the whole foul concoction would boil suddenly and shoot out of the test tube with appropriately dire consequences. There must have been generations of us who complained about doing this chore; and if you were a double-first

from Oxbridge it was something of a come-down. However, I still hold the view that these experiences in the ante-natal clinic were marvellous occasions for keeping the upper lip stiff. Benedict's reagent came into its own here—but not for much longer because the Fifth Cavalry arrived very soon after in the form of Albustix and Clinistix. When the going got dull—as it was bound to—there was always a spot of glass-blowing to be done and many a test tube changed its shape in my hands.

The ante-natal clinics were good value especially as some epidemiologist had shown that medical students were as good at guessing the weight of the baby as their masters.

It was the only part of the training where the 'your-guess-is-as-good-as mine' scenario was played out. The scanner and ultrasound devices were not generally available, but in the three years between the 'obs and gobs' block/elective and becoming an SHO all that would change—and for the better.

The days of getting on a bicycle and riding into the 'District' at night—and all hours—had gone. Mothers were increasingly advised to have their babies on the labour ward. So—it was to the labour wards of other hospitals we went.

There was a little girl, once, who read a book about penguins and, when asked what she thought of the book, she replied; 'This book told me more about penguins than I wanted to know!' The same could be said for obstetrics and gynaecology in that much of the mystery and the wonder of the female corpus was revealed. Much of the 'how' was answered in those four short months, but none of the 'why?'. Professor Jack Hunt would have approved of that. The elective shot many of us to the four corners of the world and when we came back it was to psychiatry for three months entwined with the wonders of the ear, nose and throat. More of that next time.

J H Pitt-Payne

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Professor Roger Warwick

The staff and students of Guy's who knew him will have heard with great regret of the death of Professor Roger Warwick who died suddenly on 14 September 1991 aged 78 years.

He must have been an outstanding student at Altrincham Grammar School where he was *Victor Ludorum* for three successive years and won prizes in Latin, Greek and English. At Manchester University he obtained his BSc (1935) and MBChB (1937) winning the Renshaw prize in Physiology. After house appointments in the Professorial Unit in the Manchester Royal Infirmary, he served in the Royal Navy for six years. He spent 10 years in the Anatomy Department of Manchester University where he obtained his MD (Gold Medal) in 1952 and PhD (1955) for outstanding work on the nuclei of the nerves supplying the muscles which move the eyeball. This work also won him the Symington Memorial Prize of the Anatomical Society (1953) and an Arris and Gale Lecture at the Royal College of Surgeons of England (1960).

He was appointed to the Chair of Anatomy at Guy's in October 1955 and retired in September 1980. During this time he changed the anatomy department so that it became almost unrecognizable with regard to the staff, accommodation and research. He did not achieve this without some difficulty since the preclinical departments were regarded as existing mainly for the purpose of preparing the medical students for entry to the clinical part of their course. At times his problems may have arisen because of his own personality.

Among his achievements in the department were the change in staff from three permanent anatomists and five temporary demonstrators to ten anatomists, all of whom were research workers as well as teachers, the introduction of a BSc (Hons) course (108 students obtained a BSc in Anatomy between 1957 and 1980 of whom 44 were awarded a 1st class) and accepting PhD students who were graduates from all over the world. Practically the whole department was renovated and an extra floor was added to accommodate research workers and an enlarged Special Dental Anatomy Department. As a result of his efforts two electron microscopes were installed in the basement of the department.

His early and considerable efforts to use closed circuit television for teaching at Guy's failed due to lack of financial support. He wanted to be the first to introduce this method of teaching but much to his regret it was first used elsewhere and subsequently at Guy's. Not long after he came to Guy's Roger Warwick obtained a research grant for apparatus for the purpose of studying the use of ultrasound to produce microscopic lesions in the brain. Subsequently the apparatus enabled some of his staff to develop ultrasound for research and therapy.

Roger Warwick achieved the great distinction of becoming with Professor Peter Williams, co-editor of Gray's Anatomy. They completely revolutionised the format and content of what is probably the most famous textbook in medicine. Roger was co-editor of the 35th, 36th and 37th editions and editor emeritus of the 38th edition.

He was secretary of the International Anatomical Nomenclature Committee for about 20 years and was responsible for enlarging the scope of the nomenclature

to include histology and embryology. For most of the time he was the mainstay of the committee.

Roger travelled widely as an examiner and lecturer and this enabled him to pursue his hobby of collecting butterflies from all over the world. He was also interested in archaeology and in his late years became a philosopher scientist with special reference to the role of human anatomy in relation to other sciences and the relationship between science and the arts. This is seen in the preface to the 37th edition of Gray.

Roger Warwick will be remembered for his successful efforts to modernize the Anatomy Department at Guy's in terms of improved teaching facilities and equipment and the acquisition of apparatus for modern anatomical investigations. He did everything possible to encourage and support his staff in their research. He left the Department a much bigger and better place as well as adding to the honour of Guy's by his editorship of Gray's Anatomy.

His name and that of his wife Carolyn who died in 1986 have been perpetuated by Roger's endowing four prizes at Guy's, two of which are for BSc students, a reflection of his enthusiasm for the pursuit of science in association with medicine.

JJ

Dr John Dalgleish

Dr John Dalgleish died peacefully in hospital on 30 September 1991, in his 77th year after a short illness.

Born in Woking he was educated at Radley and then entered Clare College Cambridge where he read Natural Sciences. On coming down from Cambridge he went to Birmingham University to take a degree in brewing and then joined Bass. While in Birmingham he met Jean Longhurst a physiotherapist at the Queen Elizabeth Hospital who trained at Guys and there followed 53 years of very happy marriage.

On the outbreak of war he joined the Army and saw service in North Africa and France. Following demobilisation, in spite of post war financial stringency he entered Guy's as a mature student and qualified in 1950. After house appointments he joined the practice of Higgins, Maile and Scott in Woking eventually becoming senior partner retiring three years ago.

He was a dedicated doctor nothing was too trivial for him to attend to by day or night and he firmly believed in visiting his patients at home if it was at all difficult for them to get to his surgery. He was a general practitioner in the widest sense of the word and lived up to the hospital motto of '*Dare Quam Accipere*'. He is survived by his wife, two children and six grandchildren to whom he was devoted.

WBDM

Mr Patrick Cutler

The dental profession lost a much loved figure on 18 September when Pat Cutler died quietly and suddenly at the age of 75 whilst watching television. Educated at Hurstpierpoint and Guy's Hospital Dental School he qualified in 1938, and after a spell as house surgeon to Mr Doubleday commenced practice in Southend-on-Sea where, apart from the war years, he worked for the rest of his professional career.

The stories he told of his years in the RADC from 1940–46 were high points of any dinner party, such was his sense of humour. Unfortunately the best of them were unprintable in a journal such as this but those of us that were privileged to listen to such tales can never forget the relish with which he told them and the sense of fun that he wove into them.

Returning to Southend in 1946 Pat built up his practice very rapidly indeed and became well known not only for care and consideration towards his patients but also for his sporting activities. He had played rugby for Guy's and Southend RFC before the war and it was natural for him to carry on at Southend upon his return. He played hooker for the Eastern Counties team which reached the final of the County Championship in 1948, was Captain and eventually became President of Southend RFC. During the summer his great love was cricket and for many years he was one of the driving forces behind the Southend Doctors and Dentists cricket team which played almost every week.

Pat's service to the profession locally was immense. He served on the Southend LDC from its inception in 1948 until its demise following reorganisation in the early seventies. He regularly attended section and branch meetings throughout his career and his colleagues will never forget his rather endearing habit of wearing carpet slippers after working hours virtually wherever he went. A past chairman of Southend Section and past president of Essex Branch, Pat was elected a life member of the BDA upon his retirement. He maintained his interest in the profession to the end and one of his sons continues in the practice which he did so much to establish.

He leaves behind his widow, Peggy, their three children and seven grandchildren of whom he was immensely proud. One of his sons is a Guy's dentist, the other a Guy's doctor and his daughter a Guy's physiotherapist. His friends and colleagues will miss his warmth, generosity and enjoyment of life which affected all with whom he came into contact and their happy memories of Pat will serve as his epitaph for years to come.

Students at the WPCT Congress

Students were represented at the Congress by Sasha Mayes—a Guy's student. She presented the following speech at the opening ceremony in the Barbican Hall:

'Good evening Madam President, Mr President, distinguished guests, assembled delegates.

I am very honoured to have this opportunity to speak to you this evening on behalf of the physiotherapy students of the UK.

Since the last World Congress was held in the UK in 1953, there have been many changes in the physiotherapy profession, both nationally and internationally.

From being a doctor prescribed service we have become a first contact profession of practitioners. Physiotherapists in this country now have their own autonomy, giving hope in the future for everyone to become autonomous.

Also on a national level, the physiotherapy profession has broadened its horizons and taken in a vast amount of new treatment philosophies, including advances in electrotherapy and new handling skills.

Students have been encouraged to get involved within the professional body of the Chartered Society of Physiotherapy. In the last five years we have been invited to hold our own national election for two candidates to be voted onto our council. This has allowed us to join committees and have a chance to air our personal views and become involved in issues that are important to us.

Decisions are also being made which will affect present students in the future as well as future students applying now, so it is important to have a student voice.

Further education in the form of PACE, Physiotherapy Access to Continuing Education, has been set up; allowing physiotherapists to update their skills, prepare themselves for higher level study and obtain a Diploma in Advanced Physiotherapy Studies.

This gives us an improved opportunity for personal advancement past-qualification, and very importantly, an opening for conducting research, a very necessary activity in our profession.

The schools of physiotherapy in this country are in the process of changing all their courses to a degree level, so that British physiotherapists of the future will all be of degree status, joining the level of many international countries who already have physiotherapy degree courses.

Our curriculum is being regularly updated and now includes dissertations and projects where we can research into areas of particular interest to us, as well as collating material which has interest for others.

In the next forty years before the congress comes round to the UK again, I hope that our profession will be a thinking one with hundreds of small research projects going on around the country and enriching what we have to offer to the World Confederation for Physical Therapy Congress.

As a student, I am looking forward to becoming a qualified member of the physiotherapy profession and working in an environment that is changing around us and constantly developing.

I also look forward to seeing more students in more countries becoming involved in their profession and pushing for greater integration.

Any type of governing body should always truly reflect the views of its mem-

bers, but this cannot be done unless those views are made known. Students need to be included because they will be the employers, teachers and researchers of the future. And who knows, out of students now, will there be a future Berta Bobath or Geoff Maitland?

The International Physiotherapy Students Association, IPSA, has continued to grow, with most recent participants coming from India, Thailand and Turkey, joining the long standing member countries of the UK, Germany, Switzerland and Norway.

They are holding a World Congress this year, which is being held in the UK in August.

This Association provides the opportunity to understand physiotherapy in other countries, experiencing their different approach, methods of treatment, culture and of course, social life.

The main vehicle of this activity are the summer schools held every year, usually in two or three different countries.

If you put together a group of students of different nationalities, varied friendships arise, leading to numerous opportunities to visit other countries. Thus, IPSA offers travel, education and contacts abroad.

This needs to be encouraged at postgraduate level. A wealth of experience and knowledge can be gained from travelling and working abroad, including the different ways in which specialities are approached.

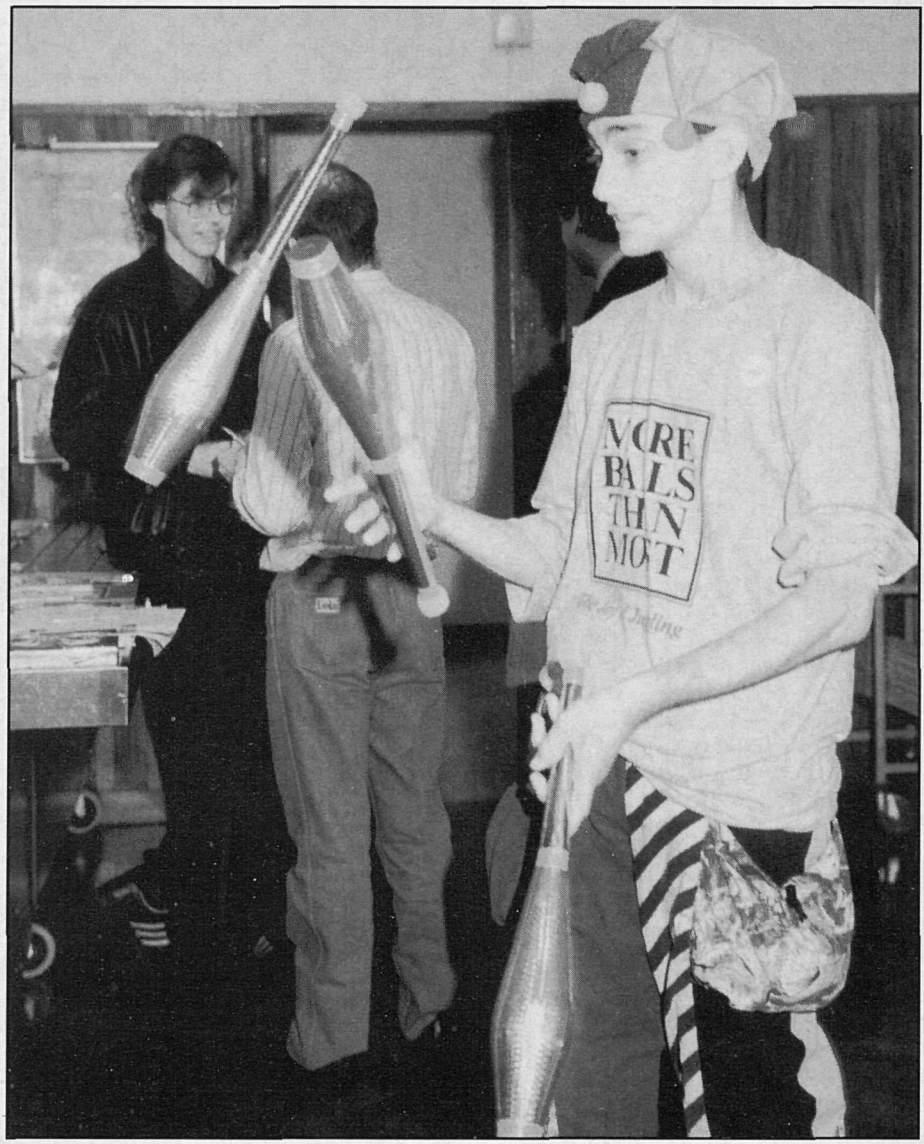
Therefore it is essential to maintain contacts with other countries, so that we can share our different opinions.

More links need to be established, more routes made for travel, more resources made available to travel and for setting up conferences to promote exchange of knowledge. More than ever, students are looking forward to working abroad once qualified as well as those already qualified, so barriers to this occurring have to be taken down. Instead of it becoming easier to work in other countries it is getting harder, with exams to take, licences to apply for and other difficulties along the way.

The European region of the WCPT has made it a priority to improve existing links and establish close co-operation between the profession of physiotherapy and others involved in health care. I hope that this will happen soon and successfully.

I am very excited to be involved in this congress and to have the chance to meet physiotherapists from around the world as well as hearing, learning and enjoying the papers and presentations in the coming week.

I am looking forward to tomorrow as well as the future'.



The Juggling Club. A new club represented at the Fresher's fair that was willing to give a reasonably safe demonstration on demand.

Freshers! The new intake of medics and dentists at UMDS.

Rugby Club

Guy's Hospital RFC v The Royal London Hospital. Won 43–3

The second match of the season could not have had better conditions for an inter-hospital match between two teams committed to running rugby. Guy's missing five players from last week may have been slightly weakened, but with the reinstatement of Mike Seare and even bigger Andy Skyme in the forwards and the return of Bunting who has been engaged in some committed training through the summer, the Guys XV was fully ready for a tough encounter with UK cup finalists, The London Hospital.

The first half opened with fairly equally weighted packs who shared the early exchanges, however the wind in Guy's favour, gave Steve Lewis the chance to pin the opposition in their own 22. Then, from a line out close to the London line, Guy's captain Roy pounced on a loose ball and drove over the line for an easy try—converted by Lewis. The London then fought back to get a penalty in the Guy's half which was converted to make the score 6–3.

At this stage the Guy's forwards superior fitness started to tell in both tight and loose phases of the game. James Combes often sniping blindly round the blind side opened up deficiencies in the London defence, and then the ball would be moved wide in the backs leading to the next try by Bevon.

This pattern continued until half time when the score was 23–3. At this stage the scoreline should have been greater but for the overenthusiastic nature and occasional tactical wildness of many Guy's players.

In the second half Guy's faced the wind but continued to dominate in an equally frenzied manner. Tries were added by Lewis, Bevan, Bunting and Worth as the London spirits were finally dulled. Twice in the second half the London broke out with great chances to score but were denied through poor handling and hard Guy's tackling.—Result 43–3.

This match has good promise for the rest of the season, particularly with many players still to return and competition for places so high. However in coming matches with less possession and fitter opposition, Guy's will have to be more productive and make fewer mistakes.

Blues Awards

At a recent meeting of the Blues Committee the following awards were made.

Boat Club

Full Blue	*Half Blue*
J Crossman	S Mayes
A Klein	Mat Smith
D Bessey	J Robbin
E Gibson	A Cash
C Burt	

Hockey (Men's)

Full Blue	*Half Blue*
Richard Russell	G Harris
K Ong	A Lall
	S Moody
	G Kooiman

Hockey (Ladies')

Full Blue	*Half Blue*
Tania Grace	Rebecca Williams
Katrina Rankin	Louise Selby
	Melinda Capps
	Penny Grace
	Emma Braidy

Football

Full Blue	*Half Blue*
T McDonagh	P Kalra
	J Thompson
	A Betts
	S Kelly

Rugby

Full Blue	*Half Blue*
J Worth	P Cunnington
W Llewellyn	J Combes
S Bunting	M Rose
	P Fewings
	R Breeze
	G Ryan
	R Llewellyn

Netball

Full Blue	*Half Blue*
Clare Walford	Alix Taylor
	Alison Currie

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Births

EDE. On 6 October 1991 at St Thomas's to Roland and Celia a son, brother for James.

PIGOT. Geoffrey BDS '79, Gillian BDS '82 (née Traynor) wish to announce the birth of their first child, James Edward born at Farnborough Hospital on 12 September 1991.

Hidcote
Orchard Road
Pratts Bottom
Kent

Deaths

LOOMES, Eric Thomas James. Much loved husband of Audrey and father of Sharon, Simon and Sally, died on 6 August 1991 at Guy's Hospital, where he gave 45 years devoted service 1940–85.

POLLOCK, Alexander Norman, LDS. Qualified from Guy's in 1954, died 9 October 1991 whilst on holiday in Hungary.

WHITE, Jean Isabella. Died peacefully on 29 September 1991 in her 81st year. She trained as a physiotherapist and radiographer, and later went on to become a superintendent radiographer.

STOCKER, Arthur Herbert, LDS, RCS (Eng.) Died 30 August 1991 aged 79 leaving a sister Constance Stocker his only surviving relative.

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Correction

The Gazette is grateful to Dr W G Tillman for pointing out that in the letters columns of the September issue Professor T B Johnston's name was incorrectly spelt.

The Tower at Guy's—September, 1972—with New Guy's House and the Tower of Hunt's House behind.

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Volume 105 Number 2418 December 1991
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
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Printed by Hobbs the Printers of Southampton

Passim

This month in the *Gazette* the not inconsiderable changes at Guys over the past four years, including the Philip Harris House and the new student bar, are heralded by Cedric Bore on his return—long awaited by *Gazette* veterans. Sadly this last month has also seen the end of the traditional Guy's Snowflake ball. However, in its' place a new joint Guy's and St Thomas' venture, the Halloween Ball, has emerged, and judging by the aftermath was successful.

With reference to the timing of recent publications of the *Gazette*, I would like to apologise for the lateness in publication and distribution of recent issues. This has unfortunately resulted in the advertising of events after they have happened. The method of production of the *Gazette* will be changing to that of Desk Top Publishing, starting with the February issue, and it is anticipated that this will be a labour-reducing exercise and will speed up production. The *Gazette* is always glad to receive articles from its readership, but it is worth mentioning that to reach the deadline of a particular issue, it is necessary to receive the article by the end of the second week of the previous month—at the latest.

Finally, since this is the last issue of the year, the *Gazette* staff would like to wish all its readers a very happy Christmas and New Year.

No more Nightingales

Dear Sir,
By chance I watched 'No More Nightingales', an overview of the restructuring of the nursing profession, on BBC1 today. At the end of the programme I felt more cheerful and hopeful about nursing and, indeed, about the world in general.

The last two items of the programme concentrated on a Bart's Ward dealing with patients suffering sickle cell anaemia crises (the Sister was wearing a GHNL badge) and the paediatric surgical ward at Guy's. Both Sisters recalled the old 'Battle Axes' to my mind! The young women were confident, knowledgeable, 'in charge' efficient, kindly and compassionate. How Sisters 'Addison', 'Mary' and 'Bright' would have relished the modern equipment and the resources on call. However, basic skills, too, have to be remembered. It is truly unbelievable that it is thought responsibility for ones 'own' patients is a new idea, or that bed-sores are not better prevented than cured, circumstances permitting.

I believe nursing is emerging from the doldrums and the poor image resulting partly from their own actions and attitudes, and more so, from outside pressures, both political and economic. 'No More Nightingales' indeed. Miss Nightingale was, after all, a radical revolutionary in her time, initiating changes at least as sweeping as those of recent years, in their way. Nurses latterly had apparently lost their way and were seemingly torn between becoming technologists on the one hand, and aspiring to be mini doctors on the other. The profession needed to redefine itself, and even more to rediscover pride in the profession as nurses.

I am grateful to have been left with such a hopeful view of nursing by the young women presented in this television programme.

Yours faithfully,

MRS GERTRUDE A FRY (Guy's 1947)
3 Kings Court
Kelsey Park Avenue
Kent BR3 2TT

Erratum

Dear Sir,
Thank you for your courtesy in publishing my letter on the Past Presidents of the Dental Society.

May I correct a printer's error (no doubt due to my appalling handwriting)? Freddie Doubleday distilled his own local anaesthetic (described in E C Hammond's article in the last issue of The Gazette), boiling up the tablets A and B in the little porcelain cups.

The brew was then allowed to stand, like a fine claret, to reach the right temperature, room or body, before using.

Yours faithfully,

Mr G A WATKINS
16 Prideaux Road
East Sussex

Brooklands museum

Dear Sir,
I was very interested to read the article by T Houlding describing 'The Brookland Guy's Gala Meeting, 1932'. Your readers may not know that some 30 acres of the site containing the original clubhouse, the wartime finishing straight hanger, member's banking and bridge and racing lock ups are preserved in a museum trust.

Exhibits of old motor cars and aircraft include the Mk IA Wellington N2980 that was salvaged from Loch Ness in 1985. This aircraft is being slowly rebuilt, mostly by volunteers and to date some 45,000 hours have been expended on it.

As a 'Friend' of Brooklands, I would be happy to conduct any individuals or parties around the site and explain what is being done.

Yours faithfully,

G T COOK, LDS
Retired Air Commodore RAF
118 Nork Way
Surrey

Brooklands success

Dear Sir,
Mr Houlding's account of the Brooklands Guy's Gala Meeting in 1932 rekindles cherished memories. I was the idiot who won the skilled driving test ruining a set of tyres on the family Riley Nine Monaco in ten minutes flat. My father was in some doubt regarding congratulations!

Yours faithfully,

MR RONALD POOK
Larkswood
Oakfield Close
Weybridge

Sleeping on the wards

Dear Sir,
I am one of those ancient Guy's sisters who slept on the ward. Mine was Luke 1930–31.

We made sure we had pretty dressing gowns as we passed through, clutching towels and 'sponge-bags' on our way to the bathrooms next to the theatres on the top floor of the old surgical block.

Dr Grasby's articles are most enjoyable and I have written to tell him so—all my vintage!

Robert Myall is my son-in-law, who met my daughter Lynne, when she was training at Guy's as a nurse.

Yours faithfully,

MARJORIE E SMITH
19205 Ross Road
Washington 98011

Grimy Guy's

Dear Sir,
I trained as a nurse at Guy's in the Sixties. I recently returned with some friends from my original 'set'.

We were *appalled* at the *dirt* everywhere. I know you are self-governing, but have you sacked all the cleaners? The Colonnade notices could not be read because no-one had washed the glass for months (or years). Everywhere was the same story. Student bicycles left to rust tied to railings, had been there so long their original owners are now probably consultants!

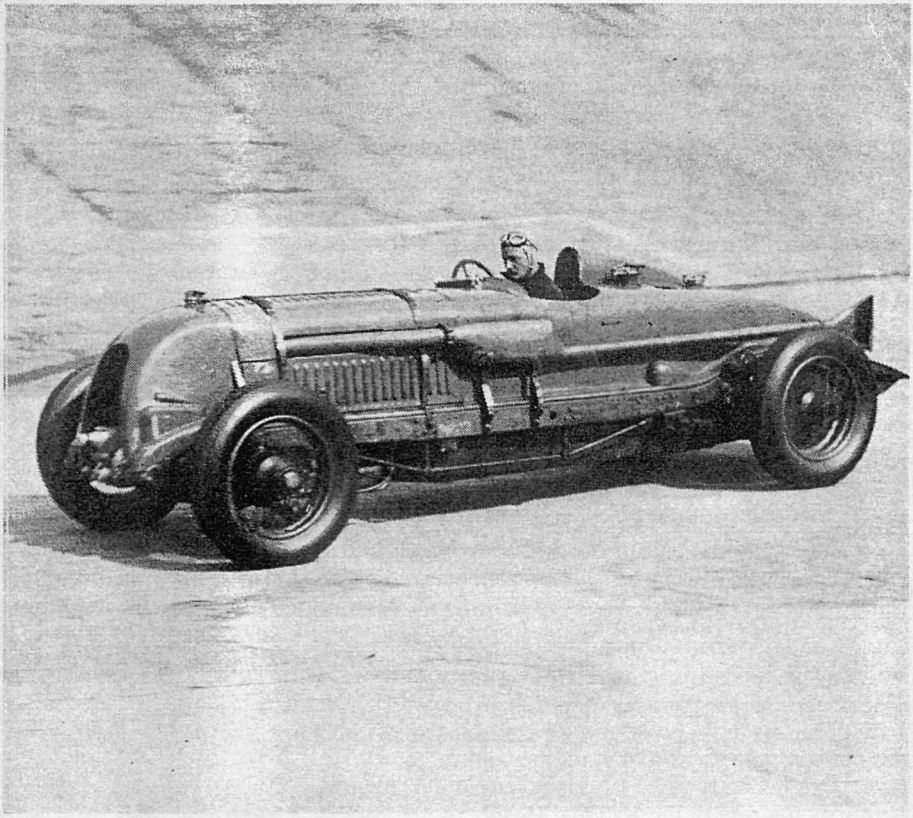
Whatever do eminent visitors think—especially from abroad? It was never like this in our day—Matron Johnson would not have allowed it.

By contrast, the Naval Hospital here (at Haslar) is spotless.

Please do something urgently about this tragic state of affairs.

Yours faithfully,

D WHITE (Miss)
78A Castle Road
Southsea
Hants



Pre-race line-up on May 9, 1930 at Brooklands

Harley Street—no myth

Dear Sir,

Indeed, 'Nothing is Truer than a Myth'—(The Myth of Harley Street, October Gazette).

Did your correspondent, DS-C, perhaps have his tongue in his cheek, or was he just being inflammatory? Either way, a visit to Harley Street would probably help his ailments. The authenticity lent to Harley Street, and which he so roundly condemns, is underpinned by the fact that there is a greater concentration of skills and expertise, readily accessible, in that small part of London than anywhere else in the country. We have all tried Borough High Street, and Carnaby Street, and the Old Kent Road, and found them wanting. Not only is there no authenticity in those dreary places, there is precious little else of merit. Patients go to Harley Street because the physicians and surgeons are there. And those key people are there, along with their peers, because the supporting services and infra-structure are there—all working well and even better than in the base hospitals. Of course, the role of the National Health Service as an increasingly munificent and protective employer may have something to do with this, but that is another story. By and large, the inept,[1] the inefficient, and the discourteous do not survive in Harley Street because the reality of market forces and the inherent good judgement of most patients would soon see through any sham.

Dare I suggest that your correspondent has become like the 'Gentlemen of England now abed' who 'think themselves accursed they were not here'. But he can be here, and his excellence will undoubtedly attract patients who will help pay the rent in Harley Street and thus make life more tolerable back at Guy's when the phones aren't answered, and porters are unavailable, and car parking becomes impossible.

Yours faithfully,

RICHARD WILSON
40 Harley Street—of course.

(1) Remarkable as it may seem, the hazardous technique of a dentist acting as operator/anaesthetist is no more illegal than a gastroenterologist administering his own IV sedation. The dentist would be pretty stupid to play the dual role, and the GDC would take a very dim view of his activity, but it is not illegal.

Brooke Lodge

Dear Sir,

Readers of the *Gazette*, who read the excellent account of the redecoration of Brooke Lodge in the October 1991 issue, may like to know that this innovation was made possible by the financial support of the Friends of Guy's Hospital. This is just one example of the way in which the Friends assist in making forward thinking projects in the Hospital possible.

Yours faithfully,

A H BURFOOT
Chairman

Bungy jumping

Dear Sir,

I recently wrote to you (August letters) about the interesting subjects of bungy jumping and '69'.

I would now like to inform your readers that Sue in the Medical School Salaries Office is going to do it for charity (bungy jumping that is).

Sue is often to be seen in her leathers roaring around London on a 1000cc motorcycle and is well known for her death defying stunts such as jumping out of aircraft, off of buildings and asking our stationery department for a roll of sellotape.

If any one would be prepared to sponsor Sue for her Bungy Jump she can be contacted on ext 2972.

Incidentally, I promised in my earlier letter to tell you if '96' has any similarity to '69'. We are still working on this and will let you have the results in the near future.

Yours faithfully,

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Run for Guy's

ADT London Marathon 1992 have nominated Guy's Evelina Children Hospital Appeal and The Kidney Patients' Association of Guy's Hospital jointly, as one of the official charities for this event. The ADT London Marathon will be run on 12 April 1992.

To convert this one-off golden opportunity to financial success the Guy's Evelina/KPA duo needs the maximum possible number of runners (with confirmed places) to run and raise sponsorship for them.

All money thus raised will be divided equally between the two Guy's charities, helping the Evelina Appeal to extend its desperately needed funding of intensive care cots, and Guy's KPA to complete their £1m appeal for the new Phase III Renal Unit.

Guy's Evelina/KPA runners will receive a special running vest (or T shirt) and headband, sponsorship forms, and an official bone china ADT London Marathon 1991 souvenir mug bearing their name and time. All, together with spouse or partner, will be invited to a celebration party in June.

In Professor Stewart Cameron, and surgeon Geoff Koffman, Guy's Renal Unit already have two runners of note in the event. Both are London Marathon veterans, especially Stewart Cameron with no less than seven such runs to his credit, three being those previously sponsored by ADT.

Readers who cannot themselves run are invited to sponsor these Guy's worthies, and encourage relatives, friends and colleagues to do so as well, using the form enclosed.

But others with places, who wish to run individually (or as a team) for this deserving Guy's combination are asked to send or phone name, address and phone number to Guy's Evelina/KPA ADT London Marathon Office, Coneybeare House, Guy's Hospital, London SE1 9RT (Tel & FAX 071 403 4089).

The Splat Squad

Guy's has declared war on thousands of birds after complaints about the mess they were making on cars and on the pavement.

Three porters (referred to as the Splatt Squad) take it in turns to sit on a bench opposite the maternity ward at dusk, and play loud recordings of a bird of prey.

But the ear-splitting screeches have upset visitors and medical students, one of whom threatened to smash the megaphone!

A Guy's spokeswoman said, 'It's really being done as a health and safety measure. People have slipped in the mess.'

One of the birdmen, Bill Kelly, remarked that the noise was not too bad but nevertheless, 'It's a funny job.'

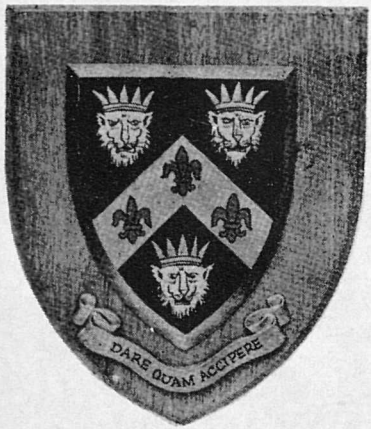
Stars charity football match

Italian pop stars took on British celebrities in a game of football on November 10 in aid of Guy's Hospital Sponsor A Cot Appeal, at Stamford Bridge (Chelsea's football ground).

The British all star team included Def Leppard, Iron Maiden, Dennis Waterman and the cast of 'London's Burning.'

The Italian side had such famous names as Gianni Marandi, Eros Ramazotti and Umberto Tozzi. Organizers say it is the first event of its kind to be staged in England.

Guy's Hospital Gazette



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Flu vaccination

Sure signs of winter included a circular from the government's Chief Medical Officer (Dr Kenneth Calman) giving recommendations on flu immunisation.

During a typical British winter, between 2,500 and 8,000 flu deaths occur. The last major epidemic was in 1989–90 when flu killed 26,000 people. More than 80 per cent of the victims were over 65, but children and young adults died too.

The commonest cause of death is secondary bacterial pneumonia.

In the 1989–90 epidemic the health departments vaccine stocks of 3 million doses ran out before the epidemic peaked, therefore this year four and a half million doses will be available costing the health department about £23m. However no epidemic is expected this winter.

Deaths could be cut by immunising certain priority groups including the elderly, people with chronic respiratory or heart disease, diabetes or immunosuppression following illness (for example AIDS) or medical treatment.

Dr Calman said the vaccine gives about 70 per cent protection against infection, and probably less in the elderly.

GPs overpaid by £6,000

Last year GPs were overpaid by almost £6,000 each because they worked far harder and more efficiently than the government had thought they would. An estimated £186m more than the amount of money set aside for GPs pay has been paid out.

The BMA have said they will keep a watchful eye to try and ensure that the government do not try to reclaim the money over the next few years.

Guy's staff win pay bonus

Guy's is to give more than 1,400 staff, mostly ancillary, a £6 a week 'thank you' pay bonus after treating 3,500 more patients than planned in the first six months after becoming self-governing. They could make the payments because, being a trust hospital, Guy's is free to set its own pay rates.

Although still £1m overspent, Hospital managers expect to balance the books by the end of the financial year. They announced that they will treat 6,000 more patients than planned by April and will reduce all junior doctor hours to 72 by April 1993—12 months ahead of the national target deadline.

They also published a patients' charter pledging specific improvements in services, including:

- Waiting lists of two years or more will be abolished from April.
- 90 per cent of the 8,000 patients on the waiting list will be seen within 12 months.
- 85 per cent of patients will be seen without waiting more than 30 minutes in out-patient departments.

Donation to Guy's KPA

Dartford Borough Council have donated £375.68 from the recycling of glass from their bottle banks to the Guy's Hospital Kidney Patients Association. The cheque was presented by Councillor Richard Jessop to Dr Chisolm Ogg of the KPA.

Councillor Richard Jessop presents a cheque for £375.68 for the KPA

GP teaching set to increase

A government commission has asked a team of experts to scrutinize the state of medical education and training. It is thought that the results of the enquiry will lead to a greater emphasis on general practice and primary health care; and may be followed by the closure of at least one teaching hospital in the capital.

Prescribing beans?—no more

Until now GPs have been allowed to prescribe basic foodstuffs, including baked beans, cherry cake, and communion wafers. The idea was to ensure that the needs of certain patients were met at the lowest possible cost. However the Health Minister, Virginia Bottomley, is to ban the prescribing of the above and 2,000 similar items - claiming there is no evidence that any of them are effective. Instead GPs will be given nine medicines and four nutritional supplements to prescribe.

Complaints drop

The number of complaints about treatment at Greenwich Borough's two general hospitals, the Brook and Greenwich District Hospital (both of which also train medical students) has dropped by 17 per cent.

A Greenwich Health Authority report said, 'Ward services undoubtedly benefitted from improved domestic staff recruitment and building refurbishment.'

Ambulances—TVs new stars

London's newest ambulances are spending too much time in TV dramas and carrying out PR work instead of dealing with real-life accidents, according to union claims.

However, a London Ambulance Brigade spokesman said that although ambulances were occasionally given on loan to TV companies, or used for charity work, it was not allowed to interfere with day-to-day emergency cover.

Patients right to records

From the 1 November, patients have been given the legal right to read their own medical records. A BMA spokeswoman said they hoped the new legislation would open up more channels of communication between doctors and patients.

However there are still some restrictions. GPs can withold information if they feel the knowledge could be harmful to the patient. Patients will also be banned from information concerning their mental health and details of abortion.

Guy's guard charged

A Guy's security guard Nigel Marshall was charged with six counts of arson after a series of fires at the hospital, and with the theft of £450 from the hospital canteen. He was remanded in custody at Thames Bridge Magistrates'.

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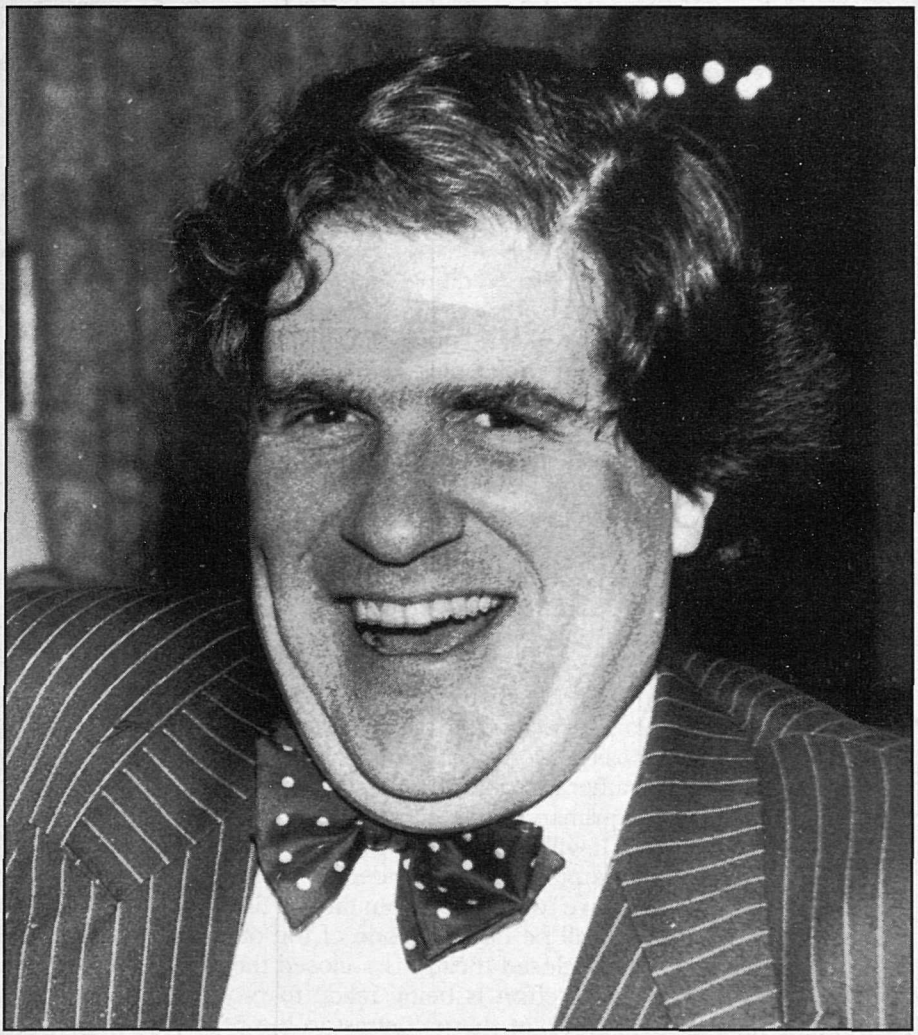
Generally Medicine

An interview with Dr Gordon Jackson, Consultant General Physician at Lewisham

Students who have spent time at Lewisham on a medical attachment can hardly fail to notice the presence of Dr Gordon Jackson. He certainly livens up many a lunchtime clinical meeting. I talked to him recently about his particular interests in career support for doctors in training and the role of general medicine in a profession increasingly dominated by sub-specialities and also about the changes in work commitment that have been the result of changes in the NHS.

Dr Jackson qualified from Guy's in 1971 after having completed his pre-clinical training in Cambridge. He has since worked exclusively in the South East at Kings, the National Heart, Guy's and Lewisham. Although greatly interested in cardiology and diabetes he had been attracted to general medicine. However the definition of what a general physician actually is presents a more complicated question. It can be considered in a number of different ways. The first and least appropriate is to consider the general physician as one who dabbles in numerous specialities, and in consequence is not able to do any of them justice. A more useful model he suggested was that it was the part of every physician's job in a district general hospital where they are involved in unselected take-ins through the casualty department. Furthermore, the future of general medicine looks set to involve physicians increasingly in the whole range of inpatient and outpatient care in a particular sub-speciality in addition to the above. There is also a rather grey area of non-organic disease which often falls between the jobs of the physician and the psychiatrist.

I then went on to ask about the emphasis placed on first hand experience of research for those seeking to pursue a career in hospital medicine. Dr Jackson believes that he shares his opinion with most of his consultant colleagues that there is 'no way you can be a hospital specialist without an understanding of research methodology, and that the best way of getting that understanding is to be involved.' There is however a question mark over the educational quality of some of the research registrar posts, and a danger that they only allow for the completion of a particular research task rather than providing effective training in research. This is somewhat similar to the situation in some clinical jobs in which juniors carry the service work load but do not receive adequate training. The aim is not to train every clinician as a fully trained clinical scientist, but rather to ensure that those who are involved in what is essentially a science based



Dr Gordon Jackson

discipline can appreciate the scientific process by having had some direct involvement.

Post-graduate education is an area where Dr Jackson has a special interest since being appointed a clinical tutor at Lewisham last year. He sees career support in the form of performance feedback and counselling services as more important than just simple 'technical teaching.' These are problems that they are currently trying to address down at Lewisham. In-service training is, he feels, a perfectly appropriate model to follow. The idea of having protected time for disappearing into lecture theatres is not appropriate. Consultants have all been registrars and senior registrars in teaching hospitals and have had teaching experience and they need to be able to spend time with their junior staff to go through case notes for example. This would provide a better approach to in-service training. What does sometimes happen though is that the clinical load is too great to do anything other than complete the service requirement. It is astonishing to Dr Jackson that although every job he has had since 1974 has contained regular undergraduated teaching, the first time that he has ever been on a course to train people in how to teach was last year after his appointment as clinical tutor. He feels that it is useful for all those in training grades with regular undergraduate teaching to have some instruction in how to approach teaching.

One of the changes at Guy's and Lewisham that Dr Jackson has welcomed is the setting up of what he sees as the British model of a clinical directorate. This was established in the mid 1980s with the active participation of Peter Griffiths, Cyril Chantler and Graham Winyard. The original idea has been taken from the States and developed further so that the management of the hospital is by directors from within particular clinical departments. He stresses that it is not a question of someone who is predominantly a manager with a token commitment to clinical practice, but rather a group of clinical consultants who spend some time in management. The primary benefit he sees of this is that one no longer has 'them'—the management. It will no longer be a case of decisions being imposed on clinicians by administrators. Unpleasant decisions, such as the closing of theatres or beds may still have to be made from time to time, but the advantage will be that the decisions will be made by one of the other consultants. One might argue however that a closed theatre is a closed theatre, no matter who makes the decision. A lot of effort is being made to provide clinicians with appropriate management skills, in sharp contrast to the provision of teaching skills training. Currently the South East Thames region has one of the most advanced management training programmes involving a three step process. There is an initial assessment of potential management strengths and then a two day introductory course. The first of these courses was in October. This is then followed by a more extensive management traning course imported from the States. It is important to note that managing a hospital is very different to

managing in industry. It is irritating to people like Dr Jackson that the press seem to imply that managing hospitals is easy. He would rather place it amongst the most difficult management tasks. It involves looking after a substantial amount of high-tech activity as well as employing a large number of people in relatively low-tech work and it entails dealing with huge sections of the general public in a service capacity at a stress point in their lives. The clinical director of medicine at Lewisham controls a budget that is similar to that of a medium sized British company and consequently bears a considerable responsibility.

Dr Jackson commented that over the years there has been a change in the pattern of work which has led to the job becoming tougher in practice although maybe not apparently not on paper. There is now so much scope for medical intervention where before one could only sit back and wait. Despite this however, he would neither encourage nor discourage his children from pursuing a career in medicine. There is nothing else he would rather be doing since he cannot think of anything that would combine the breadth, the technological and scientific pursuits and the people-based activities that a career in medicine provides. He sees the firm establishment of proper career counselling and support for doctors in training as one important step in making the profession more attractive. Particular attention should be paid to the difficulties faced by women at the start of their professional lives due to the current career structure.

FFH

The Bore Report

Four years—a long time in the life of Guy's

As many of the older readers of this venerable publication will know I, Cedric Bore, have not published my monthly column for over four years. The reason for this extended period of absence has been due to a protracted stay in India to assist Great Aunt Bessy who was having trouble with her tea plantation.

Following numerous narrow escapes in Beirut and Afghanistan I have once again come home to my beloved Guy's Hospital.

My, how things have changed! I'm sure most of the undergraduates will never have heard of my ramblings before (the editor probably included) as I have certainly never seen most of them before. But as ever, in our small community, friends can always be found lurking in dark corners drinking from paper bags before starting their afternoon lists, and new and amusing acquaintances can easily be made.

On arriving back at Guy's I tried to park my car in the field behind the tower, next to the Thomas Guy tennis courts. However, as soon as I had got out and locked the door a load of ready mixed concrete was deposited on my bonnet. Initially I thought that the starlings must have got larger, but I had misguidedly tried to park in the middle of Philip Harris House; I thought the view was unfamiliar.

I then tried to park in Great Maze Pond only to be asked to pay and display or receive an iron boot on one of my wheels. How nice to see that commercialism has not crept into our hospital.

I then wandered into the Spit and was glad to see that over four years the quality of fare and service offered has remained unaltered. In fact the only thing that has changed is the price!

I thought I might sample the lunch time delicacies offered by the 'new and historic' Guy's bar which I have heard was removed lock, stock and barrel from the poop deck of the *Herald of Free Enterprise*. Apparently the Bar Manager was also on the *Herald* on that dreadful night which might explain his friendly and happy-go-lucky manner.

After the aforementioned shocks I needed to make numerous phone calls to calm down my strained nerves. How very convenient it is to have three phone booths in the foyer of Boland House. How very inconvenient not to have any phones in them—a minor problem as a walk along the colonnade has always had a pacifying effect on me.

I've also learned that for a brief period even the *Gazette* tried to grow above its station but was rightly reduced back to size by its vocal readership.

What a sensible choice as it can once again be secreted in a white coat pocket and subsequently secretly read in a stimulating tutorial. (I can't understand why anyone would want to hide their *Gazette*—Ed).

These are a few of the changes that your correspondent then has noted at first glance. I wonder what other more intimate changes will be noted in next month's report.

Cedric Bore

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

The Friends of Guy's

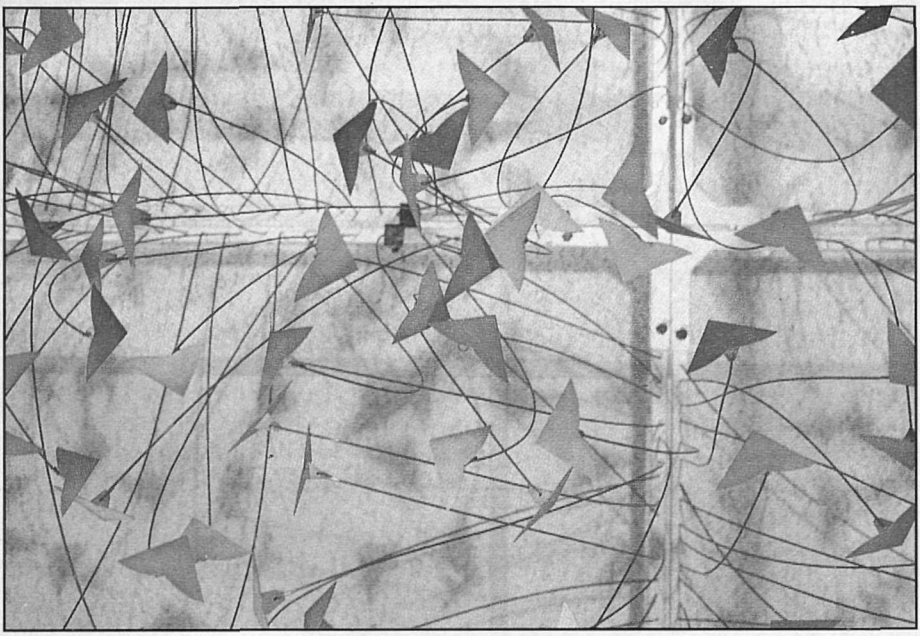
Butterflies in the eye of the beholder

Nearly everyone has visited a home or hospital ward where the very old and frail are cared for. It can be a pretty gloomy experience; there is usually a television but no-one is watching, the patients slump in chairs or beds and stare vacantly into space. Its hard to tell what they think, if they're happy or sad. The bright chatter of the television mocks the silence.

We used to go to such a place from school: a group of boisterious teenagers with guitars. The idea was that we would brighten the lives of the patients with our songs and our enthusiasm. Our departures were always quieter than our arrivals. We were left with an abiding impression of bleakness, of the crushing loss of dignity and autonomy that goes with old age, the loss of hope.

I was reminded of its years later when as a result of an accident I had to lie on my back for a few weeks. It was difficult to look at anything but the ceiling. Very quickly all the little cracks and splodges that go unnoticed in ordinary life assumed a horrible familiarity. The cracks and splodges started to look like a map, a dreary representation of the narrow world to which I was confined. It was a glimpse of how life might be for others: for the elderly and frail who lie in bed for years and years. For them, the cracks in the ceiling could become more familiar than the features of a loved one or even the faces of the nurses who care for them.

I'm not a gloomy person. I don't carry such thoughts around with me and it certainly wasn't in the forefront of my mind last year when, for the first time, I attended a meeting of the Executive Committee of the Friends of Guy's. Arriving late and feeling rather shy, I sidled into the Governors' Court Room where the meeting had already started. There was an imposing oval table, the Chairman in the distance and an array of unfamiliar faces. None of this was unexpected. What came as a complete surprise were the two young men kneeling on the floor in the middle. They were holding up models of what looked like squadrons of blue butterflies on fine metal stalks. The young men were artists who wanted the Friends to let them cover the ceiling of Brooke Ward with butterflies to provide a visually stimulating environment for elderly long-term patients. The project would be quite expensive and there was lively debate about its merits. How would it look? What effect would it have on the patients? What would the visitors think? Was the idea daft or courageous? The medical staff were convinced that the butterflies would improve the environment and boost the morale of all who live and work on Brooke Ward and the enthusiasm of the senior nurses was infectious.



Ceiling Sculpture at the Brook Lodge

That was eighteen months ago. The butterflies are there now, a mass of turquoise-blue. Their colour seems to change with the light and their long dark stalks are like the weave of a great net from which they have broken free.

Opinion is divided. A nurse told me she wished they were a different colour. I asked one of the resident patients what she thought of the butterflies. 'Those rosebuds up there?' she said, 'I like them. Very nice pink rosebuds they are.'

At the end of the ward there was a man lying in bed. He looked as if he had been there a long time, as if his world had shrunk to the small space around him. He wasn't able to tell me what he thought but his eyes were open and he was looking up. Not at cracks and splodges in the ceiling but at butterflies.

A great number of grants have been made by the Friends both before and since that day last July. There have been grants for medical equipment, research, decorations, carpeting—some of the things were quite ordinary, others complicated and expensive, but all were important to the patients and staff of the hospital. The butterflies were something of a risk, something of an adventure, but they showed the spirit of the Friends—flexible, generous and positive. In these days of change and turmoil Guy's needs the Friends more than ever before and the Friends need more members. Why not join us in 1992? Be part of something that matters.

For details contact Pat Hutton on 071 407 1058.

Philippa Blake-Roberts

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ENT And Psyche

Hear no evil, see no evil, speak no evil

I never got to find out why they'd put ENT together with psychiatry, but that's how it was in 1968. I'd had my own T's and A's whipped out when a child and then been duly transfused a couple of pints. In those days it was glass bottles and red rubber tubes with Mist. Ferri. Ammon. Cit. after food for what seemed like weeks afterwards. I got to hate that woman who came and jabbed my juvenile thumb with a sharp needle and then sucked upwards with a pipette. However, to have haematemesis at the age of five is a never-to-be-forgotten experience and maybe it was just as well the psychiatrists were standing by when I came to this section of the training. I count myself as especially lucky to have had Pip Reading as a teacher. I was surprised at the lengths he was prepared to go with all of us on his firm to make sure we learnt how to examine the ears, nose, and throat. All of us who knew him will remember that he stood on a box to operate because of his small stature. We also knew he was a giant in his field, and, in the operating theatre, it was immediately apparent that we were in the presence of one of the all-time masters of the craft. Whether it was a stapedectomy down the microscope, or the full rigours of the 'Commando resection', Mr Reading went in under full sail with a command of anatomy that made him a safe pilot in the shallows of the head and neck. Those Thursday afternoons when he did a laryngo-pharyngectomy, and R H F Brain attended to provide a colon transplant to fill the gap, were extraordinary occasions and I wondered that the human frame could withstand what it did; but it did and the patients always recovered in due course. His teaching sessions were eagerly awaited as he was so kind to us students. One afternoon, he told me that my uncle, L G J Pitt-Payne, had been ENT House Surgeon at Guy's in 1927 and taught him the rudiments such as he, Mr Reading, was doing for me in 1968. 41 years to complete the circle is a long time, but then medicine is like that. The correct identification of what lies in the external auditory meatus—and beyond, in the nose, down the throat—is down to him.

Less pleasant, though, was having tongue depressors applied and tiny mirrors on sticks placed in the oropharynx. My gag reflex never allowed for that kind of thing and it was a relief to know I was not alone—but very nearly alone. Then there were those head mirrors which we sported; those ones with the hole in the middle. The correct application of illumination down the throat never really came to me and I'm still a torch-and-say-ah man myself. Snaring polyps was rather disgusting but it was all in a days work for Mr Reading who would snare them for us and then invite one of us to pull them out. His capacity to see up the

nose seemed miraculous and many's the time we watched, fascinated, as he pulled various foreign bodies from the nostrils whilst I wondered at the strange processes whereby they'd come to be there in the first place.

Tonsillectomies were always good value. Mr Reading used to tell a story about how one tonsil had gone missing after it had been removed. He had done the operation at another place and those were the days when one kept one's trousers on and wore white gowns to do surgery. Apparently he found the missing organ in his trouser turn-ups as he was preparing for bed one night; not a very savoury story but true nonetheless. He was also very generous to the nurses working in theatres; allowing them to assist him and even letting them perform under his guidance—an event which they would never forget. Adenoids, of course, were the work of a moment as I'm sure they still are. His skill was magical in that everything he did was done with a swiftness that was memorable and modest. One of his favourite words was 'scotch'. It's not a word we hear much these days but to 'scotch an infection' was a phrase he regularly used. Or, if operating on a bleeder he'd touch the base of the artery and say: 'Scotch that!' and we did whereupon the thing would dry up with a crack and a sizzle.

Psychiatry, on the other hand, was a very different kettle of fish and I have to admit that I was probably too young to really know what was going on. I must have been getting on for twenty-one when I sat at the proverbial feet of Dr J J Fleminger. I don't know quite what I expected from a psychiatrist, but whatever it was then Dr Fleminger, known universally as 'Flem', certainly had it. So did the charismatic David Stafford-Clark. Elsewhere, I have written that a psychiatrist is a person who has dived deeper, stayed down longer, and come up dirtier than any of his colleagues. In retrospect, I know these men were at the sharp end of the ongoing search for meaning in the human psyche, but as medical students there were some of us that did not pay the subject the attention we should have done. I believe that I may have been one of these students. We all did a stint down at St Olave's Hospital where Dr Arthur Oldham held court and we sat in on his outpatients. There was the two week stay at Bexley Hospital where we wallowed in the peculiar atmosphere of a good old-fashioned asylum—and made sure we always locked the windows downstairs in the medical quarters last thing in case of the stray nocturnal visitor; a fact of life which had unnerved not a few who went before me. At Bexley, I was fortunate enough to meet a senior registrar, Dr Edward Herst, and it was he who took us to psychiatric outpatients at St Nicholas's Hospital, Plumstead, where we saw his technique which seemed like a breath of fresh air as he introduced us to the ideas of C G Jung. Later on in life, I was to spend eight years before the mast, as it were, learning more about the great Swiss psychologist. His lightness of touch with us students won him many friends and admirers. There were a couple of sessions with Dr James Willis at St Giles Hospice, Camberwell, where we saw the

early stages of the new management skills that were to be needed in the management of drug addiction; a fact of life that was rapidly to become more and more of a problem. Nor can I forget Sir Gerard Vaughan who regaled us with the rudiments of child psychiatry in the Bloomfield clinic.

He was Dr Vaughan then, a very human man who sat on the edge of his desk and shared information in a very man-to-man sort of a way. I found him very endearing.

Psychiatry in the sixties presented us students with the tip of an iceberg and it was only a matter of time before I discovered my own deficiencies as my own ship of state came up against the submerged part of this iceberg as it presented day by day in the great wilderness of general practice. It became clear, all too quickly, that a thorough knowledge of human behaviour would be a '*sine qua non*' if I was to be an efficient, psychologically-aware doctor.

However, there were other matters that took up my time. In 1968, The Todd Report on Medical Education was published, and, at about the same time, for reasons which totally escape me, I was made Chairman of the Student Medical Education Committee (SMEC). Typically, I knew little or nothing about Medical Education but I was helped on my way by Dick Trompeter who found himself being made the Honorary Secretary of this outfit at the same time as me. Once a month we had an interview with the Dean, Dr George Houston. It was he who tested the water of medical student opinion via ourselves, a feat which took some acclimatization. He was a most excellent dean and had the happy knack of being able to put us at our ease so we could regale him with the current gripes of our fellow students, and, believe me, we always seemed to have something we wanted to say. In response, he would tend to agree with us; saying things that were always prefaced with the phrase: 'Yes, gentlemen—between these four walls, I agree with you, but . . .' We usually left his office feeling quite pleased with the way things had gone and, no doubt, he may have felt that the students we represented had been appeased for another month. As my year in office drew to a close, there was the problem of arranging a properly democratic election, and it was to the occupational therapist at St Olaves Hospital I turned in order to get the five hundred or so envelopes printed together with voting papers. I would never have had the time to do all this if it had not been for their kind offices and I shall always be grateful for their help. Dick Trompeter subsequently became editor of the *Guy's Gazette* and is now the paediatric nephrologist at Great Ormond Street Hospital.

J H Pitt-Payne

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Mr Adrian Needham Henry MB BCh BAO MCh FRCS FRCSI

Adrian Henry was appointed Consultant Orthopaedic Surgeon to Guy's Hospital in sequence to T T Stamm in 1967. He retired on his 60th birthday, June 22 1990, fell ill in March 1991, and died on October 13 the same year. By every standard, his was a life of unusual achievement.

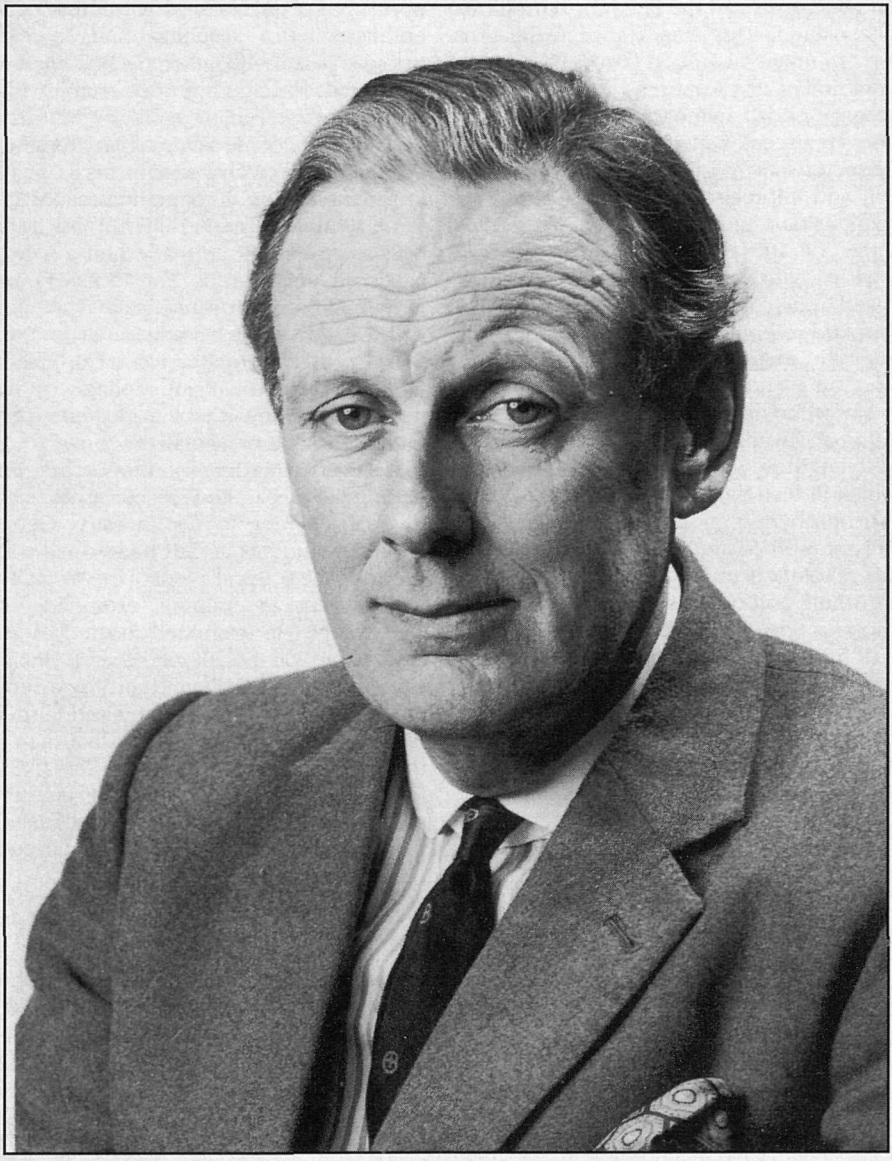
He was born in Dublin in 1930 into a family of the medical establishment. Both his parents were doctors but the inevitability of his subsequent career was by no means clear from the start. The prospect of following his father, Professor of Surgery, or his even more famous uncle, A K Henry, Anatomist and Surgeon, could hardly have been easy.

The young Adrian, fresh from school days filled with sporting achievements, took himself off to the Dublin College of Art, and even toyed with the idea of a life in the saddle. After a year, parental pressures prevailed and Adrian was obliged to seek a proper job. He qualified MB BCh BOA through Trinity College in 1954 with honours in Surgery, after a student career remarkable mainly for its extramural activities. These included racing in Dragons and Fireflies representing his University and being a reserve for his national team at the Helsinki European Games. His competetive drive on horseback took him into the Irish Grand National and though he completed the course he was uncharacteristically not placed. He continued to paint and exhibited in the Irish Royal Academy.

His postgraduate training in England exposed him to orthopaedic influences of unusual force. At Preston, Scotty Garden was defining the grades of hip fracture, a classic work in use to this day. At Bristol Royal Infirmary the inspiring teacher Eyre-Brooke and the electric Ken Pridie made a profound effect on the young Henry. He transferred as senior registrar to the Middlesex Hospital where, as elsewhere, his teachers Philip Newman and Rodney Sweetnam, became his lifelong friends. He spent a year on exchange in Jamaica where he wrote his Master's thesis on Fibrous Dysplasia and led the local polo team. Finally he came to Guy's, but with no sense of finality.

It is often the case that in the first five years of a consultant's appointment, seeds are sown which later bear rich fruit. His first commitment was to children's orthopaedics at the Evelina Hospital and later to the particular problems of deformity in cerebral palsy. Here in the Newcomen Centre the time he spent studying the complex patterns of paralytic inco-ordination led him progressively away from the cut and thrust of classical orthopaedics, towards instruction, persuasion and encouragement, the core of physiotherapy and physical training which he knew so well. His teaching to students at Guy's and his lectures to the orthopaedic world emphasised not only the patients' physical difficulties, but also the problems of parents and close relatives in coping with emotions far beyond orthopaedics. His influence in this area saved uncounted patients from harmful intervention.

But his greatest contribution was to surgery of the knee. In 1969 he made a seminal visit to Robert Jackson in Toronto, a friend and colleague from Bristol, who had worked with Watenabe in Japan. Adrian brought an arthroscope back to England and set up his special knee clinic at New Cross, the first of its kind in this country. At once he recognised the potential for pre-



Mr Adrian Needham Henry

cise diagnosis and the need for scrupulous observation. This was a special time for Guy's in general and, in particular, for our department at New Cross adjacent to the Hume Kendall gymnasium for rehabilitation. Meniscectomy, so often prescribed, so frequently mismanaged, was always a difficult and imprecise operation. Within two years Adrian had published a prospective series of 100 consecutive arthroscopies together with their preoperative diagnoses based upon clinical signs. This became the standard reference and made the case for scientific method against clinical impression, once and for all.

Many might have rested on this reputation and waited for the halt and the lame to beat their limping path to his door, which indeed they did. But Adrian's greatest contribution in this field was at once to call to his office nine like minds, excited by the revolution in surgery of the knee, to constitute and establish the British Association for Surgery of the Knee, of which he was founder and first president. Adrian's gift as a communicator and co-ordinator did not rest there. He co-founded and chaired the International Arthroscopy Association and the European Society for Knee Surgery and changed the face of sports medicine. A whole generation of athletes owe the conservation of their knees to these initiatives.

Adrian understood the need for constant reappraisal of work and results. In the early 70s he established regular clinical review meetings at Guy's long before the use of the blunt term audit with its overtones of accountancy. From work for these clinical research meetings, many registrars and colleagues published papers which helped to establish this new speciality in surgery.

The rather old fashioned epithet 'clubbable' is one that fits Adrian well, not just because of his gregarious nature, his love of company, and his wit, but because of his enthusiasm for teaching and learning through personal contact. He belonged to, and regularly attended uncountable clubs and societies. The most important is the Royal Society of Medicine of which he was Councillor, Secretary and in his last year President of the Orthopaedic Section. The same affability, natural charm and keenness to communicate made him a natural academic ambassador. The British Orthopaedic Association sent him as Travelling Fellow across the United States in 1967, Guy's sent him to the John Hopkins in Baltimore and the Royal College of Surgeons' Travelling Club made him their Orthopaedic Representative.

His understanding of bloodstock and breeding would allow us to attribute his love of teaching to his ancestry. Generations of students at Guy's rated his ward round as the surgical event of the week. His involvement in training extended into assessment. He examined in the MB and Fellowship on behalf of several Universities and Royal Colleges, earning a reputation for patience, sympathy and fairness to the flustered. He became Chairman of the Court of Examiners for the Royal College of Surgeons of England. Postgraduate specialist training made broader demands than our reduced orthopaedic department could provided after the sad closure of New Cross.

Adrian took the initiative once more to set up a committee to co-ordinate the Registrar Training Circuit between Guy's and St Thomas's before the amalgamation of the medical schools, and progressively this collaboration extended out into the provincial towns. These administrative skills were soon recognised at regional level, and he worked to co-ordinate training throughout the South East, and was advisor in orthopaedic services.

His delight in the English language was evident in the detail of his carefully crafted stories, reflecting time spent in composition. He was a fine *raconteur* and proud of his uncle Arnold K Henry whose style he would often quote and mimic. This and his surgical common sense made him a particularly valuable member of the editorial board of the Journal of Bone and Joint Surgery.

Space does not allow more than this sketchy outline of the life of this truly Renaissance man who retired from Guy's before his statutory date; not because he had no more to contribute, but because he had too much; not from fatigue, but from an excess of energy. He sought outlets in equestrian sports, from polo to point-to-point; if he was not actually taking part, which was unusual, he was in attendance to pick up the pieces of riders less skilled than he. He fished the length and breadth of these islands and sailed off most of their shores. His constant first love of art is reflected in the home he shared with Ros and their four children, one of the prettiest little houses in Kent.

The local community have lost their industrious Master of Fox Hounds, a rural accolade held in higher esteem than a knighthood, with duties for conservation and agricultural protection over an extensive area of the home counties. British orthopaedics has lost a major influence and Guy's a loyal son, equal in the tradition reaching back through 'Batch', Stamm, Lambrinudi and Trethowan to Arbuthnot Lane.

ML

Miss Doris Pugh

Many Guy's men and women will learn with sadness of the death on 14 October of Miss Doris Pugh.

Miss Pugh was a member of the medical school accounts staff from 1947 to 1977, becoming a senior member of the staff and serving the School with great devotion and loyalty. Her particular responsibilities included the disbursement of LEA grants to students, and the preparation of the Clubs Union budget and the keeping of its accounts. In consequence, she must be well known to most of the students of that long span of years.

Unseasoned treasurers of the various clubs and societies knew how firm she could be; most of them also came to know her unfailing helpfulness. The Clubs Union cannot have had a greater champion, and the honorary life membership which the Clubs Union gave her on her retirement, was a token of regard and gratitude which she greatly appreciated.

Our sympathy goes to her immediate relatives in their bereavement.

Seeing is believing—or is it?

The 1991–92 Guy's Hospital Dental Society Programme was launched on the evening of the 10 October with the Presidential Address given by the newly elected president, Mr E J Whaites. After a brief introduction from Mr Capewell, the new Honorary Secretary, our illustrious Dental Radiologist modestly accepted the badge of office from Mr Cardwell, accompanied by thunderous applause from the capacity audience—composed of a healthy proportion of staff as well as students, including a large number of 'freshers'. Indeed, it was unfortunate that the out-going president, Professor A H R Rowe, could not be present to witness the 'ceremony' since it was he who very kindly inaugurated the Presidential Medal during his highly successful year in office. As the ovation died away, the audience settled back to listen to the main presentation of the evening.

'Dental Radiology is an exceptionally boring subject!', was one of the speaker's opening remarks. On hearing this, the theatre once again erupted with even more cheers than before—mainly from the more senior students present! However, as the title suggests, the topic for discussion, even though portrayed in a pleasantly light-hearted manner, is one with very serious implications. With a broad selection of well-presented slides, Mr Whaites began to convey, to the enthralled listeners, the apparent ambiguity that preys upon the unsuspecting analyser of radiographs—or, more correctly, 'shadowgraphs'; remember *X-rays are only 2-dimensional representations of a 3-dimensional object*!

The take-home point of the lecture was that even though humans each may view the same physical image on the eye's retina, that is have precisely the same sensory input, the way this information is processed within the brain is, by no means, a constant mechanism. Indeed, a large variety of factors play an integral part in colouring an individual's perception of an image: the context in which the image is seen: the extent by which the partial image is completed by the viewer; the size, constancy, and depth of the image; and cross-cultural and human sex differences. The lecturer, with great wit and vigour, showed how, from the dawn of civilisation, man has attempted to disprove the dictum 'seeing is believing'. One particular example used was that of the Greeks who realised, when building the Parthenon in Athens, that if the structural geometry of the temple was totally accurate, it would appear to the naked eye as being conspicuously askew (the architects of Guy's Tower please note!).

Mr Whaites has a reputation among dental students of giving lectures with more than just a degree of audience participation—this was no different! Staff and students alike were expected to write what they thought they saw in various optical puzzles. One had to try to picture a dog within a mass of dots, an elephant from random lines and a steamship from a load of squiggles!

The speaker ended the evening's entertainment with a slide depicting a particular character from the BBC comedy programme 'Allo Allo!'—or was it just another optical illusion?

The members of the Dental Society would like to thank Mr Whaites for all his effort in producing such a thought-provoking and illuminating presentation, and we wish him all the best in his new position.

Avijit Banerjee

Blood and thunder in 'Max-Fax' surgery

Having conjured up images in my mind of maxillofacial surgeons as being ominously cloaked figures silhouetted eerily against the powerful operating lights, menacingly brandishing razor sharp scalpels dripping with blood, and laughing manically as they begin their meat carving sessions—I thought long and hard about attending this lecture. Fortunately, in hindsight, I made the correct decision, but what had I let myself in for?

Mr I L Hutchinson, consultant oral surgeon at St Bartholomew's Hospital, claimed to be 'honoured to be welcomed back to the lions's den!'—a reference to his period as registrar at Guy's, and to previous lectures. However, I'm sure it was the captured audience who fell victim to Mr Hutchinson's dynamic efforts portrayed in the lecture, which exuded immense courage and incredible skill from each incision!

The lecturer decided to tackle his huge subject from a historical perspective. From the turn of the century it was realised by general surgeons that in cases of severe facial trauma, the relative positions of both the maxillary and mandibular teeth were the key to reassembling the facial deformities that had occurred. With this in mind, Mr Hutchinson led us down the path of surgical development in this field, beginning with a variety of teeth splinting techniques (to attempt to orientate the mandible and the maxilla and thus allow the other features to fall into place), right through to modern-day osteoplasties to repair skeletal defects and deformities.

He then moved on to alternative operating techniques to cure particular problems, for example—zygomatic arch fractures by initially using a 'modified tyre lever', but nowadays using a Poswillo Hook. Orbital floor defects can be repaired using sections of pigskin placed in the appropriate position. This was graphically portrayed by a number of slides taken during one of these procedures.

After covering this aspect, Mr Hutchinson then delved into the more 'glamorous' side of oral maxillofacial surgery—the type of surgery that you or I imagine these people to do day in, day out—that is, reconstructing people's faces, or more clinically, performing facial osteotomies of various types! A particularly pertinent point was made at this stage—the bread and butter work done by this particular oral surgeon includes apicectomies and complex extractions and this is a dentist with extra-surgical training, and not the other way around. Having said this, examples were shown of extremely complex procedures ranging from rib implants to rectify deformities associated with Crouzon's syndrome, to genioplasties and arthroplasties to correct ankylosed temporomandibular joints—indeed, by this stage in the proceedings, the latter operation was required by many members of the packed audience, whose jaws were permanently resting on the carpet with astonishment and admiration!

Mr Hutchinson's library of slides was gruesome enough to grace even the most horrific of horror films, but they were also clinically stunning and did due justice to his great talent. The end of the presentation was greeted with a loud ovation and also groans of relief from the student members of the audience—I'm sure the buffet supplied after the lecture went down very well!

The audience was invited to ask questions, but was probably still reeling from the visual attack it had just sustained. Thus, it was left to the members of staff to men-

tion the contentious issue of the training required to become an oral surgeon. Mr Hutchinson put forward an interesting proposal of having a basic degree course lasting for three years in the pre-clinical medical and dental sciences, followed by a further two years post-graduate course in either clinical medicine or dentistry, after which appropriate specialist training could be pursued by the suitable candidate.

So, to answer my initial concern, what I had let myself in for was one of the most interesting and eye-opening lectures with dramatic illustration, that has been presented to the Dental Society, and for this we all convey our thanks and appreciation to Mr Hutchinson.

Avijit Banerjee

New Director of Nursing

Vanishing P45 forms, in the company of senior nursing staff, have been a confetti-like phenomenon over recent months. It is a welcome sign to see a reversal of this situation. As the September *Gazette* briefly reported Guy's and Lewisham now has a new Director of Nursing; she is Wilma MacPherson, until joining Guy's, Chief Area Nursing Officer for the Grampian Health Board in Scotland. She had previously been Director of Nursing Services at the Aberdeen Royal Infirmary.

Wilma MacPherson has wide experience in both education and management within nursing. She believes nursing at Guy's must see development of a strategy for professional links across the Trust. The quality of nursing care must be constantly reviewed, with nurses being aware of their responsibilities to patients.

Wilma hopes to visit a ward or patient area on an almost daily basis. Thus nursing staff should become familiar with her presence, and come to recognize she is a very approachable person. She says she is happy to be called 'Matron' if that makes her position clearer to patients and staff, although she has no intention of wearing the uniform characteristic of this post in former days.

Fully aware that nursing at Guy's, and often elsewhere, has suffered from low

morale, she avers this is difficult to quantify. Reorganization has altered the traditional structure leading to feelings of insecurity, nurses not always knowing who has responsibility for leadership. Wilma admitted that low morale here could be attributed to the devastating publicity which has surrounded the arrival of Trust status with some strange allegations appearing in the press. Clinical grading has created many opportunities but at the same time it generated problems; Wilma intends to review the structure for senior nurses.

Wilma only supports statutory training programes for qualified nurses, as envisaged by PREPP, provided they are relevant and fulfill the objectives set for them. 'Customer care training' is important for nurses; PREPP is part of the process for nurses to take responsibility for their own development. Gaps in training should be sought out. Individual Performance Review (IPR) should ensure that five or six key areas have achievable goals.

Project 2000, the new scheme under which student nurses will attain their supernumary status reflects the changing role of staff at the bedside and in the community. Health Care Assistants will replace student nurses at many tasks, but Wilma thinks Auxiliaries can be very useful, if an accurate skill-mix study has been conducted. She added that, for the service side, senior nurses will be looking at key issues for building the future. Amongst these are clinical care, quality of practice and communications.

Wilma's record covers training in both nursing and midwifery. She held a variety of posts as Sister at both Glasgow and Aberdeen during which she undertook the Diploma of Nursing, London University, in 1974. She held the post of Nursing Officer at Aberdeen while its Phase 2 building was commissioned, so she is well prepared for our own Phase 3, expected soon. A lot of her professional practice has been associated with research and development; she holds an MSc in management studies, and has held academic posts at Aberdeen and Glasgow. Apart from this impressive background she has many links with nursing in England, and was invited earlier this year by the Secretary of State for Health to be a member of the Clinical Standards Advisory Group.

Wilma told me her welcome at Guy's has been warm without exception, and she did not feel a stranger here, in England. As part of her relaxation she is keeping her house in Aberdeen, but her cats are here with her. She enjoys reading, music and visiting the Royal Academy, especially the Pop Art Exhibition (open until December 15).

She sees the nursing contribution to the Trust as significant, and it must include important features: *1* clinical audit, which should be developed out of medical audit as part of a team effort, *2* a nursing development unit should be set up, *3* clear links with education must be forged, and *4* health service research, in conjunction with medical colleagues and all other health service staff.

We wish here well in leading the nursing team.

Denis Cobell

America—by bike

This summer, I was asked to join a team of cyclists as their physiotherapist. The plan was to cross America over a period of ten weeks, covering 4,700 miles in aid of the London homeless. Great! What a way to take a break before I started work as a physio here at Guy's.

I met the team on a training weekend in Yorkshire over Easter when my physiotherapeutic skills quickly fell into insignificance as I became team cook. The '25 State Trans Am' team (so called as we crossed 25 different states) consisted of six cyclists and three support crew. We were all students or recent graduates. The support crew consisted of myself and a doctor (we cycled alternate days) and a mechanic who drove (and repaired) the van.

We arrived in San Francisco on 8 July (having been kindly flown out by Virgin Atlantic) to spend a week confirming contacts and building the bikes. We used lightweight 12 or 15 speed touring bikes. Our low budget meant camping for the majority of the time.

On 16 July we left a very foggy Golden Gate Bridge to begin our journey. We averaged around 80 miles a day. The longest day was 130 miles and the shortest around 50. The Rocky mountains slowed us down a little.

The cyclists had done a varied amount of training and it showed! Very quickly I was called upon for sore and stiff legs, backs and necks (there was little I could do for the saddle soreness!). Gradually though these all became fewer and fewer although the Rockies and Appalachians later on provided me with a few painful knees to sort out. As we crossed the Nevada Desert with its amazing long flat roads there were other problems. Many miles were covered in the mornings (we would leave at 5 am as soon as it was light) but the afternoon heat, in excess of 45°, was too much. Cyclists suffer from 'the bonk', similar to a Marathon runners wall, and running out of water was a very real concern In fact only one person suffered from heat stroke and that was a particularly stupid physio who refused to stop until she either got there or fell off (oops!)

American hospitality was all and more, that it had promised to be. As we travelled we became more and more well known and received a good deal of media attention. So much so that by the time we reached New York people had already seen us on TV. There are many tales of great free meals out and places that put us up (most memorable was a town in Texas who let us stay in their five star hotel for two nights and gave us a free run of the bar. We sat and watched ourselves on TV and drank in the air conditioning!)

Each of the six cyclists cycled every inch of the way, a miracle considering the traffic and various hazards. These included killer truck drivers (see 'Duel' for details), mad dogs, who with us were out in the midday sun, and cattle grids which were cunningly hidden and exactly the right size for a front wheel. There were amazingly only two crashes in the trip, both of whom were put back together again. I had to cycle with one cyclist for a couple of days to give 'on the road treatment' but we made it.

On September 26 we crossed the New York—Connecticut border and were treated to a meal of a lifetime by a kind restauranteer. America was a pleasant surprise. We saw few cities and tourist attractions as we crossed from San Francisco via New Orleans to New York but instead saw another side of America and its people plus

some spectacular scenery. We are still collecting sponsorship money but expect to have raised around £20,000. A most worthwhile summer all round.

Joanna Stubbs

The Halloween Ball

With soaring overheads and decreasing attendences, rumour was rife that there would be no Snowflake Ball this year. Faces were drawn long and many had reached the point of cracking when . . . enter the Halloween Ball.

Yes, the annual institution of fun, frolicks and subsequent short term amnesia was back. Advertised almost exclusively to freshers, whispered about in dimly lit corners, the Halloween Ball was sold out well before the advertising posters appeared. The date, Friday 1 November, a cool autumn evening. The centre of UMDS attraction was the Warldorf Hotel, the venue of many previous UMDS balls, and now the place of the first ever Halloween Ball.

Revellers flocked to the champagne reception; men dressed sharply in dinner suits, women shone dazzingly with their new hair styles. The atmosphere was warm and conducive as dinner was announced.

The main hall was perhaps a little compact and after a few technicalities, dinner was served. The evening progressed to the mandatory food fights—reminiscent of Snowflake Balls—that were thankfully restricted and swiftly curtailed by the raffle draw. The prizes were wonderful and generously provided by a host of sponsors.

Before long, Plasma had flared up their speakers, and even before you could say 'Hey! Where'd that dance floor appear from?' the opening bars on the first track were blaring as the crowd took to the floor *en masse*.

Sometime during the blur of the evening I heard someone say 'I feel sorry for those staying on the first floor?'

'Not half as sorry as I feel for those cleaning up,' someone else replied. Indeed, in the true nature of (Snowfall) Halloween Balls, nothing stood in between revellers and the resulting *mêlée*.

The evening finally came to an inceremonious end half an hour before advertised, much to the crowds disappointment and the managements relief: a mix up about the bar's liscence, it later emerged.

Thus, the first Halloween Ball drew to a close. The Snowflake may be no more, but the Halloween promises to be back, and probably with a vengeance. Hearty thanks should go to all that helped in the organization of such a mammoth event.

S B Popat

Screen Printing at Guy's

In Boland House there are screen printing facilities that can be used for printing your design of logo onto garments. This is ideal for clubs, sporting events or charities. We can provide T-shirts, polo shirts and sweat shirts at very competitive prices. This facility can be used by anyone at Guy's—not just medical students. Please use our own facilities rather than outside companies, as any money we raise will go to Amalgamated Clubs. For details phone myself or Shereen Rahman on 081 691 8103 or leave a note in the windsurfing club pigeon hole—first floor of Boland House.

Heidi Miller

Smiles all round at the Halloween Ball

Struck Off and Die

The show begins with a sketch highlighting the supposed aphrodisiac properties of the white coat, Drs Gardner and Hammond dancing to 'I'm too sexy' while swinging their stethoscopes.

Following two television appearances and shows at the Edinburgh Fringe, the two doctors (Guy's and St Thomas's trained) present a jaundiced view of career advancement in both hospital medicine and general practice. The jokes are strictly medical (as are the audience), and also extremely funny—medical degrees are handed out during the course of the show.

To reach the top in hospital medicine, it appears that it is essential to adopt a suitably subservient manner on the ward round, and take bloods fast enough to get to the 'Roses' before the night sister. According to some of my clinical colleagues, many of the sketches ring very true e.g. the categories of 'heartsink' patients—including the 'I'm a medical mystery—me!' patient.

The duo have been criticised as 'smug' and 'self-satisfied' (Review 90)—why should two doctors become comedians? It becomes clear during the show, that this may be an effective way to focus attention on the very long hours worked by most junior doctors, whilst possibly restricting the duo's career opportunities somewhat!

Robert Self

Men's Hockey—UMDS II

There was a certain freshness to the start of the season, a new team, new kit and a new captain. Spirits were high as we left Boland House for our first match and we made quick time towards Maidstone. However, once it was discovered that Maidstone was not the correct destination (thanks Matt) we hurried to reach Edenbridge and proceeded to lose fairly heavily. A number of our matches since, have followed a similar course but the goal deficit is diminishing the more we play together and we may soon jump out of the red and into the black. Another positive is that we have had two victories and a draw which gives me cause to believe that the future looks as though it may be promising.

Both our freshers have performed quite commendably so far. Hugo continues to impress with skills both on and off the pitch and Paul has proven to be very useful in midfield. Other notable performances include: Neil our heroic goalkeeper who has made some good saves and doubles by playing right half from time to time together with Cung whose eye for the ball is usually quite sharp unless fogged by his previous night's frolics.

I must not finish without saying thanks to the rest of the boys for making the first half of this season very enjoyable and by making my life easier as a result of their dedication and motivation towards each match. Finally, I must mention Billy who has been a very efficient secretary even though he does wobble a bit both with and at the ball!

Abhi Lall

Rugby Club

Guy's Hospital 1st XV v Metropolitan Police
Won 52–3

Possibly the only club match being played on the afternoon of England v France; Guy's were pressured by their dictatorial skipper into an afternoon kick off. Despite his unpopularity, Roy managed to harness his side's irritation and channel the agression into the Police side who traditionally are amongst the more abrasive sides that Guy's play.

In the first half with the wind in Guy's favour the ball was used cleverly by fly-half Neil Davies to put Guy's into attacking positions. Uncharacteristically Guy's were dominated in both tight and loose phases of the game, which gave the backs first class possession with which to run. With this and the constant driving play of the forwards in support, the Met had little to match. This pattern of play brought tries for Bevan, Worth, Skyrme and Ryan with one disallowed for full back Matt Rose. Half time score 22–0.

In the second half Guy's raised their game against the wind and against the periods of Police pressure and were in inspiring form with rolling mauls and charging runs from Thomason, Beardmore and Co. The scrummage was the strongest of the season, winning every scrum in the second half and resulted in a hat tick of tries for Skyrme from push overs. The backs also maintained pressure with Worth, Bevan and Rose all adding further tries. The only points for the Police came from a penalty by their fly-half when his side were about forty points down—imaginative play that did little to raise his team's morale.

This match did much to restore confidence after the previous weeks defeat by Old Cranleighons, but I feel this Metropolitan Police team was much weaker than in most years and Guy's still have much work to do before the league season commences.

Jeremy Worth

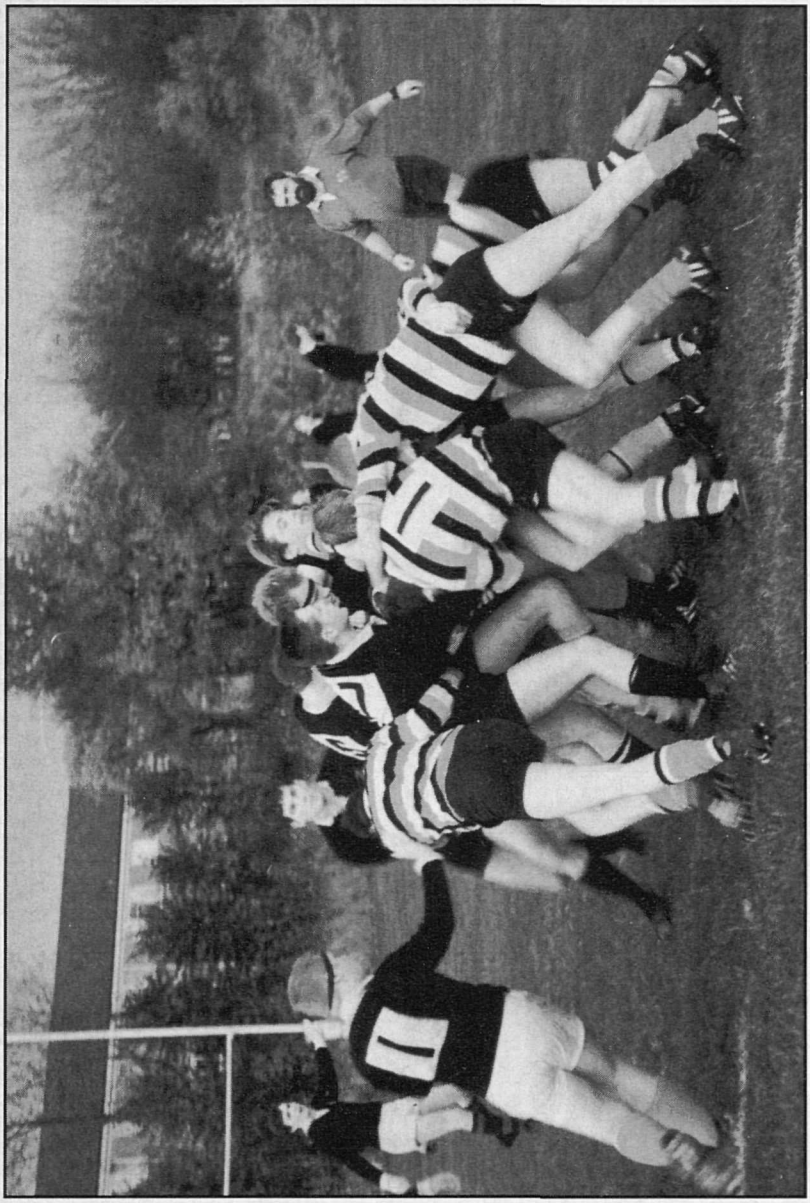
Guy's Hospital 3rd XV v Old Emanuel Nov 16. Won 22–12.

The preceding two games had been lost against robust sides which had deprived the Guy's forwards of useful possession. The difference on this occasion was that the pack dominated. In the scrums, the Guy's players were able to exert a good shove although this became less effective as the game progressed. Conversely, the lineouts improved as Rose managed eventually to leap above his opposition. The ground was firm, the air still, so the youthful Guy's backs had plenty of opportunity to run.

The first score came early when Conchie picked up a loose lineout ball and broke a tackle. Lloyd converted from near the touchline. Guy's maintained the pressure although lapses of concentration and some shoddy passing prevented at least two more tries. After some good passing and straight running Bailey scored the second try. It was almost too good to be true when following another move in which several players handled the ball Lloyd went over near the posts. There then followed a furious ten minutes before the interval when the opposition capitalized on Guy's overconfidence by scoring two goals. Thus from an unprecedented superiority of 14–0, Guy's changed ends leading by only 2 points.

Old Emanuel were revived by their changed fortunes and played with more determination. Their big centres were held several times near the Guy's line. However, as soon as the Guy's players passed along the backs, they revealed the potential to add to their score. In one magnificent phase of play the ball was passed from one touchline to the other and back into the middle of the field. Underwood frequently joined in from fullback to make the extra man in attack. Lloyd's defensive kicking took some of the heart out of the opposition. Russel and Seargent were always up in support and participated in several moves which foundered just short of the Old Emanuel line. It was fitting that the final try was scored by the captain, Hawker as he broke down the blind side of the scrum. An enjoyable game.

Team: C Howell, T Gibson, M Holden, T Rose, R Dales, J Murphy, R Scanlan, J Conchie, J Hawker (Capt), T Lloyd, M Howells, J Seargent, S Bailey, S Russel, K Underwood.



UMDS 2nd XV v Royal Free (lost)

Deaths

MARSH, Jimmy died suddenly on 26 October 1991. Good friend and mentor to many Guy's people and generous benefactor to the Hospital. Landlord 'Ye Olde Kings Head', Borough High Street, September '49—October '70 and Duke's Head, Bromley, October '70—October '87. Remembered fondly by family and many Guy's friends.

Marriage

Mr Leonard Rowlands LDS, qualified 1928—Renate Hodgson, daughter of Arthur Deichmann, consultant surgeon, Dusseldorf, Germany. Married on 11 June 1991 in Tunbridge Wells.

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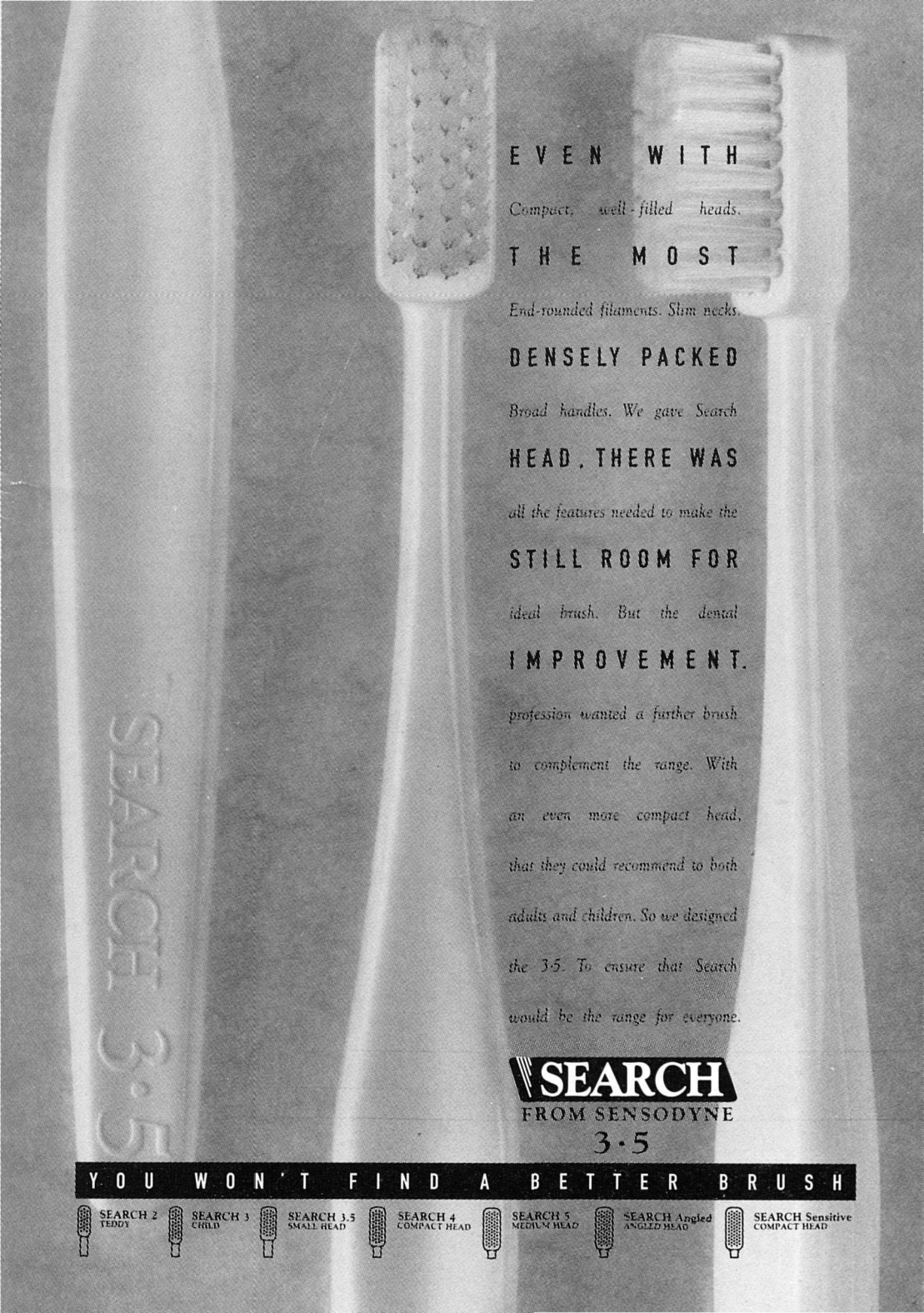
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